



# Christian Healthcare Ministries

*The biblical solution to healthcare costs*

The Rev. Howard S. Russell *President*  
127 Hazelwood Avenue • Barberton, Ohio 44203  
330.848.1511 *phone* • 800.791.6225 *toll free* • 330.848.4322 *fax*  
hrussell@chministries.org • www.chministries.org

Dear Friend:

I am sorry to hear of your medical need. I want you to know that all of us here at the Christian Healthcare Ministries office are praying for your recovery. We will especially lift you up during our chapel services each Thursday morning at 9:30 a.m. Eastern time.

In times like these, facing a world of uncertainties can cast a shadow over us that hides the face of Jesus. Don't be discouraged. Before the onset of time God knew this day would cross your path, and even then He began to prepare you and those around you. He knew just what it would take to see you through this difficult time. He will not fail you now.

Sometimes the weight of a physical ailment is multiplied by the concern for the financial burden incurred. However, thousands of Christians are ready to help you. While your needs are being prepared for sharing, please accept the following advice. It will make your next few months much more comfortable.

When you have a medical need, don't hesitate to tell medical providers that you are "self pay." Also, tell them that you are part of a ministry of Christians who share each other's medical bills. **In the last 20 years, CHM members have shared more than \$500 million of other Christians' needs.** They will now help shoulder your burden as well.

Please don't hesitate to ask for reductions on your bills. Health care providers regularly give reductions to insurance companies and will not be offended if you ask. Additionally, obtaining reductions will save money that can be used to help other CHM members. Providers often will give you a reduction much greater than what they would give CHM on your behalf.

Within this packet, you will find more detailed information about medical needs processing. If you have questions, please don't hesitate to call or write us so we can help you.

God bless you in your time of need.

Rev. Howard S. Russell  
President and CEO



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## What to do when you need medical care

### In emergency situations:

- 1) **Immediately seek medical care.** Call 9-1-1 if the situation is life threatening. If you are a Gold member and your condition is less serious but requires immediate care, consider if an urgent care center will meet your needs (emergency rooms are usually more expensive than urgent care centers).
- 2) **Seek financial assistance when you are well.** Getting well is your first priority. When your condition is stable, you, a friend or a family member responsible for your care can follow steps under “General information” below.

### In non-emergency situations:

- 1) **Consider “shopping around” for health care providers in your area.** You’ll find that some health care providers are more willing than others to reduce their charges for self-pay patients. Although you may go to any hospital or doctor office for treatment, selective “shopping” helps lower the cost of your medical care because you often can choose to receive the same service at a lower price. To compare health care pricing in your area, visit [www.healthcarebluebook.com](http://www.healthcarebluebook.com) and [www.hospitalvictims.com](http://www.hospitalvictims.com). You also can contact the CHM Reductions department (1-800-791-6225, ext. 5797 or [reductions@chministries.org](mailto:reductions@chministries.org)) at any time for advice.
- 2) **Follow the steps under “General information” below.**

### General information:

- a) **Inform the health care provider—in an emergency, usually a hospital—that you are a self-pay patient and a member of Christian Healthcare Ministries,** a group that will help with your bills after other forms of assistance have been exhausted. At all times carry your CHM membership card so providers will understand your situation (remember to tell providers to bill you directly).
- b) **Ask for a bill reduction (discount).** Asking for a discount is asking for the same consideration that insured patients receive (due to discounted rates negotiated by their insurers). Many providers will extend a discount to you because it usually means they receive faster payment. Discounts represent nearly 60 percent of all medical bills submitted to CHM, so please don’t be shy about asking. Also, any discount (on an eligible medical bill) you help obtain will apply toward your personal responsibility amount (Gold: \$500; Silver: \$1,000; Bronze: \$5,000).
- c) **Whenever possible, contact the CHM Reductions department before accepting a discount or making a payment.** If you have difficulty obtaining a significant discount, our staff can help negotiate with your health care provider(s) to make sure you get the best possible price for your medical care. Remember that if you pay the bill up-front, negotiations cease. Please don’t make full payment up-front.
- d) **Apply for any financial assistance available.** Many members are surprised to find that they qualify for financial assistance, which is money set aside for the express purpose of helping patients. Ask to speak to a financial counselor or decision-maker and complete any forms they give you.
- e) **Ask providers to bill you directly and set up a payment plan with your providers.** Work with your providers to make whatever monthly payments you can afford until CHM members share your eligible need, at which time their voluntary

-more-

gifts reimburse your expenditures. Even minimal payments will reassure most providers that the bills will be paid.

**f) When you receive your itemized bills, send copies of each bill to Christian Healthcare Ministries, along with the completed Needs Processing forms.** CHM must receive your bills and forms within six months of the date of service. Send the bills immediately—even if a discount is pending—because bills are shared by CHM in the order they are received by our office.

We are all aware that sometimes circumstances far beyond our control take place. **To ensure that each medical need is received, please make copies of each of the items you send to our office.**

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## CHM Needs Processing department

We are pleased to be of service to you in this time of need. If you have any questions or concerns regarding your need, please feel free to contact us at 1-800-791-6225 and ask for the processing representative for your state:

### **Region 1**

*Connecticut, Delaware, Indiana, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, Rhode Island, Vermont, West Virginia*

**Donna Greer**

**Ext. 8088**

**[dgreer@chministries.org](mailto:dgreer@chministries.org)**

### **Region 2**

*Alaska, Arizona, California, Colorado, Hawaii, Idaho, Kansas, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oregon, South Dakota, Texas, Utah, Washington, Wyoming*

**Beth Kabellar**

**Ext. 8086**

**[bkabellar@chministries.org](mailto:bkabellar@chministries.org)**

### **Region 3**

*Arkansas, Illinois, Iowa, Kentucky, Louisiana, Minnesota, Missouri, Oklahoma, Virginia, Wisconsin*

**Yvonne Woolridge**

**Ext. 6104**

**[ywoolridge@chministries.org](mailto:ywoolridge@chministries.org)**

### **Region 4**

*Alabama, Florida, Georgia, Mississippi, North Carolina, South Carolina, Tennessee*

**Tina Farnsworth**

**Ext. 8087**

**[tfarnsworth@chministries.org](mailto:tfarnsworth@chministries.org)**

# Needs Processing Form



Christian Healthcare Ministries *Galatians 6:2, Acts 2 & 4*

Return form to: **Christian Healthcare Ministries**  
Attn: Needs Processing

127 Hazelwood Ave.  
Barberton, OH 44203

330-848-1511 phone 800-791-6225 toll free  
330-848-4322 fax  
www.chministries.org

Please read and complete the following form for sharing of your medical bills. ATTACH a separate sheet of paper giving a brief explanation of the incident of illness.

## MEMBER INFORMATION

Member number: \_\_\_\_\_ Primary member name: \_\_\_\_\_

Reimbursement address: \_\_\_\_\_

Home phone: (\_\_\_\_) \_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_ Cell phone: (\_\_\_\_) \_\_\_\_\_

Name of member's church: \_\_\_\_\_ Church phone: (\_\_\_\_) \_\_\_\_\_

Church address: \_\_\_\_\_ Church fax: (\_\_\_\_) \_\_\_\_\_

## PATIENT INFORMATION

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_

If the patient is between 19 and 23, is he or she also taking a minimum of 5 college credit hours per semester?

Yes  No Name of school: \_\_\_\_\_

## PHYSICIAN'S DIAGNOSIS

Physician's diagnosis: \_\_\_\_\_ Date symptoms began: \_\_\_\_/\_\_\_\_/\_\_\_\_

*Remember to attach a separate sheet of paper giving a brief explanation of the incident or illness.*

## PREVIOUS CONDITIONS

Did you have signs, symptoms, or treatment of this condition before joining CHM?  Yes  No

## ACCIDENTS ONLY

Accident occurred at:  Home  Other (specify): \_\_\_\_\_

If the accident occurred on property other than your own, all bills must be submitted to the responsible party's insurer. Please submit a copy of letter of approval/refusal for payment.

Since Christian Healthcare Ministries members are considered self-pay, we strongly advise that you take advantage of any financial assistance programs that you might be eligible to receive. This information is provided in order to facilitate timely filing for these programs and to lessen the burden of rising medical costs on fellow members. If any other source will pay **all or any part** of your bills for this incident, you must send documentation verifying payments (See Guideline E.2).

*I understand that CHM members participate out of a desire to share one another's burdens, and it would be an abuse of their trust if I use the money I receive for a shared need for some purpose other than payment of that need. If I have prepaid or made payments, I will consider funds received from CHM as reimbursement. I understand that failure to provide accurate information or failure to use the money for the submitted bills will be a violation of Christian Healthcare Ministries Guidelines.*

Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Continued  
on back...**

**IMPORTANT: FAILURE TO COMPLETE THIS FORM WILL RESULT IN PROCESSING DELAY.**

**WORKSHEET AREA**

Complete each column of this WORKSHEET AREA. Send the itemized bill for each line completed below along with this form.

**IMPORTANT! Special instructions:**

**REDUCTION(S):** When a bill reduction is received, your itemized bill should reflect the amount of the reduction.  
**PAID BY OTHER SOURCES:** Some examples are Medicare, insurance, Workers' Compensation, etc.

<b>DATE</b> <i>of service</i>	<b>PROVIDER</b> <i>doctor, hospital, pharmacy, etc.</i>	<b>AMOUNT</b> <i>of bill</i>	<b>REDUCTION</b> <i>(if any)</i>	<b>PAID</b> <i>by other source</i>	<b>BALANCE</b> <i>due</i>
1.	_____	\$ _____	\$ _____	\$ _____	\$ _____
2.	_____	\$ _____	\$ _____	\$ _____	\$ _____
3.	_____	\$ _____	\$ _____	\$ _____	\$ _____
4.	_____	\$ _____	\$ _____	\$ _____	\$ _____
5.	_____	\$ _____	\$ _____	\$ _____	\$ _____
6.	_____	\$ _____	\$ _____	\$ _____	\$ _____
7.	_____	\$ _____	\$ _____	\$ _____	\$ _____
8.	_____	\$ _____	\$ _____	\$ _____	\$ _____
9.	_____	\$ _____	\$ _____	\$ _____	\$ _____
10.	_____	\$ _____	\$ _____	\$ _____	\$ _____
11.	_____	\$ _____	\$ _____	\$ _____	\$ _____
12.	_____	\$ _____	\$ _____	\$ _____	\$ _____
13.	_____	\$ _____	\$ _____	\$ _____	\$ _____
14.	_____	\$ _____	\$ _____	\$ _____	\$ _____
15.	_____	\$ _____	\$ _____	\$ _____	\$ _____
16.	_____	\$ _____	\$ _____	\$ _____	\$ _____
17.	_____	\$ _____	\$ _____	\$ _____	\$ _____
18.	_____	\$ _____	\$ _____	\$ _____	\$ _____
<b>TOTALS:</b>		\$ _____	\$ _____	\$ _____	\$ _____

**Checklist before mailing:**

- 1. This signed and completed Needs Processing Form
- 2. An itemized bill for **each** item listed above with documentation of payments and/or adjustments (reductions)
- 3. A letter explaining the circumstances of this incident
- 4. Signed and completed Pastor's Form
- 5. Signed and completed Authorization for Disclosure of Health Information Form

**Failure to submit any of the above items will delay the processing and sharing of your bill(s).**

# Authorization for Disclosure or Use of Protected Health Information Form



Christian Healthcare Ministries

Galatians 6:2, Acts 2 & 4

Return form to: Christian Healthcare Ministries  
Attn: Needs Processing

127 Hazelwood Ave.  
Barberton, OH 44203

330-848-1511 phone 800-791-6225 toll free  
330-848-4322 fax  
www.chministries.org

## SECTION A: (PLEASE PRINT)

<b>Name:</b> _____	<b>Address:</b> _____
<b>Date of birth:</b> _____	_____
<b>SSN:</b> _____ <b>CHM #:</b> _____	<b>Phone #:</b> _____

I understand that Christian Healthcare Ministries is a not-for-profit medical cost sharing organization that coordinates assistance for its members' eligible medical bills. **Christian Healthcare Ministries is not an insurance company, nor is it offered through an insurance company.**

I hereby authorize any medical practitioner, hospital, health facility, insurance company or any other person or entity that has medical records or knowledge of the medical records of the undersigned and/or the dependents listed herein to disclose my protected health information to Christian Healthcare Ministries and The Karis Group, a partnering patient advocacy group, for the purpose of facilitating the eligibility and sharing process by Christian Healthcare Ministries and also negotiating medical bills on the undersigned's or dependent's behalf.

I further authorize Christian Healthcare Ministries to discuss any and all health information related to my records described in this authorization with the above health care providers, health care facilities, health plans or any other agency involved in my health care or payment for health care.

## SECTION B:

Description of information being disclosed:

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Complete Health Record   | <input type="checkbox"/> Discharge Summary           | <input type="checkbox"/> Progress Notes    |
| <input type="checkbox"/> History and Physical Exam  | <input type="checkbox"/> Consultation Reports        | <input type="checkbox"/> Laboratory Tests  |
| <input type="checkbox"/> Abstract/Pertinent Information   | <input type="checkbox"/> Emergency Department Record | <input type="checkbox"/> Radiology Reports |
| <input type="checkbox"/> All records regarding all bills, billing codes, diagnosis codes, and other billing information |  |  |

## SECTION C: By signing below, I understand that:

- This authorization shall expire upon the expiration of one (1) year, or until revoked by me in writing, whichever comes first.
- This authorization is voluntary and that I may revoke the authorization in writing addressed to *Privacy Officer at 127 Hazelwood Ave, Barberton, Ohio 44203*. This authorization may not be revoked where Christian Healthcare Ministries has already reasonably acted in reliance upon this authorization.
- The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by federal or state law.
- Treatment payment, enrollment or eligibility for cost sharing may not be conditioned on execution of this authorization.
- A copy of this form, including a facsimile, may be used in place of the original.

Signature of Individual or Authorized Representative	Print Name of Individual

Representative's legal authority to individual	Print Name of Authorized Representative

Today's Date: \_\_\_\_\_

**IMPORTANT: FAILURE TO COMPLETE AND SUBMIT THIS FORM WILL RESULT IN PROCESSING DELAY.**

-- PROVIDE COPY TO MEMBER & COPY TO FILE --

This form is certified HIPAA compliant.



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## PASTOR'S FORM

**To be completed by the pastor or church official (If the patient is the pastor or member of the pastor's family, another church official must sign the form.)**

Dear Pastor:

Christian Healthcare Ministries (CHM) helps our members meet their medical bills, thus fulfilling Galatians 6:2, that Christians carry each other's burdens. One of our members attending your church has submitted a need for sharing. The individual submitting the need—or the individual for whom the need is submitted—must meet the following criteria:

An individual must be a Christian living by biblical principles and believe the Bible teaches that members of the Body of Christ are to share other Christians' burdens. A member must be an active participant in the Body of Christ, demonstrating the fulfillment of Hebrews 10:25. Persons who engage in a sinful lifestyle as described in the Scriptures do not qualify as participants in Christian Healthcare Ministries.

Please understand that in completing this form you are not being asked to judge your parishioner's Christian experience. According to our Guidelines, it is necessary for us to know certain facts related to the expression of his or her faith. Please help us by answering the questions below to the best of your knowledge.

**Member's name:** \_\_\_\_\_ **CHM #:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**Patient name:** \_\_\_\_\_ **Patient age:** \_\_\_\_\_ **Patient SS#:** \_\_\_\_\_

- |   |                              |                             |
|---|------------------------------|-----------------------------|
| 1. Does the person listed above (if over 18 years) strive to live by biblical principles?           | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Does he or she attend church regularly?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Does he or she refrain from participating in a sinful lifestyle as described in the Scriptures?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Has this need been presented for consideration to the benevolence committee of the local church? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Name of church: \_\_\_\_\_ Church phone #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Pastor or church official's signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(If you are the pastor or church official and the need submitted is for you or a family member, you must have another church official sign this form.)*

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Attn: Needs Processing  
127 Hazelwood Ave.  
Barberton, OH 44203

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