Need Request Form

Authorization	
Any person who knowingly attempts to defraud any company, files a need request containing any materially false, incomplete or misleading information, is guilty of a crime. I hereby certify that the answers I have made to the foregoing questions are both complete and true to the best of my knowledge and belief. I have read the fraud notice included in this for	
Primary Member's Signature	Date
Patient's Signature	Date

Primary Member Information

First Name	Last Name	MI	Prefix	Suffix	Gender	SSN	
DOB		Phone			Email		
Street		City				State	Zip
Employer's Name		Member ID Number				Payroll Frequency	

Patient Information (person whos is sick or injured)

First Name	Last Name	MI	Prefix	Suffix	Gender	SSN	Date of Birth

*By providing your e-mail address above, you consent to the use of electronic transactions in connection with your SHA policies, contracts, and/or accounts to the extent available permitted by law (which may include, but not limited to: invoices, claim correspondence, contracts, surveys, and other materials that SHA is, or may be, legally required to deliver to you).

SUBMIT NEEDS TO: Alliance For Shared Health
3155 Sutton Blvd, Suite 201
St. Louis, MO 64143

Call: 877-232-3811

Please sign the attached HIPAA form and return it with the completed claim form.
*******If filing a need request within the first policy year for benefits, medical records may be requested*******

Is medical treatment due to an injury? ☐ No ☐ Yes

If yes, provide the date of the injury. ______

Describe how the injury occurred ______

Is treatment related to an illness? ☐ No ☐ Yes

If yes, complete the following questions related to the illness.

What is the illness diagnosis? ______

When did symptoms first occur? ______

What is the first date of treatment for the illness? ______

If diagnosed with cancer, what is the date of the initial diagnosis? ______

(Attach a copy of the pathology report.)

Was the patient treated by any other physicians for this illness or a related condition? ☐ No ☐ Yes

If yes, provide the physician's information below.

Treatment Date	Physcian Name	Address	City, Sate Zip	Phone

Complete the remaining sections for ALL claims.			
Patient's primary treating physician:			
Physician Name:	Address:	City, State, Zip:	Phone:
Was the patient confined to the hospital as a result of this condition? ☐ No ☐ Yes (If confined, please submit copy of patient's admission and discharge papers or a copy of a UB-04 billing invoice from the hospital.)			

1. Attach an Itemized bill and submit this claim form with the itemized bill attached to the address below
2. If you were hospitalized as a result of this sickness, you must include a copy of the hospital bill indicating your diagnosis and number of days hospitalized
3. If the claimant is over 19 and a full time student, please enclose a copy of proof from the institutions registrar
4. In order to document the contents of this form, claimant must sign the completed claim form

Authorization to Obtain Information

MAIL TO: Alliance For Shared Health
3155 Sutton Blvd, Suite 201
St. Louis, MO 64143

Call: 877-232-3811

Primary Policyholder's Name:	SSN	Date of Birth
Policy Number:		
Address:		
Name of Individual Subject to Disclosure (If not the primary Policyholder):		Date of Birth
Relationship to Primary Policyholder:: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Child ☐ Stepchild ☐ Grandchild		

I. Authorization:
For the purpose of evaluating my eligibility for assistance and for benefits under an existing membership, including checking for and resolving any issues that may arise regarding incomplete or incorrect information on my application for membership and/or need requst form, I hereby authorize the disclosure of the following information(defined below) about me and, if applicable, my dependents, from the sources listed below to Alliance for Shared (ASH), or any person or entity acting on its part, to include a third paryt administrator (TPA).
II. Disclosure of Health Information:
Health information may be disclosed by any health care provider, health plan (including ASH or TPA, with respect to other ASH or TPA coverages) or health care clearinghouse that has any records or knowledge about me. Health care provider includes, but is not limited to, any licensed physician, medical or nurse practitioner, nurse, pharmacist, osteopath, psychologist, physical or occupational therapist, chiropractor, dentist, audiologist or speech pathologist, podiatrist, hospital, medical clinic or laboratory, pharmacy, rehabilitation facility, nursing home or extended care facility, prescription drug database or pharmacy benefit manager, or ambulance or other medical transport service. Health information may also be disclosed by any insurance company or the Medical Information Bureau (MIB). Health information includes my entire medical record, but does not include psychotherapy notes. Some information obtained may not be protected by certain federal regulations governing the privacy of health information, but the information is protected by state privacy laws and other applicable laws. SHA will not disclose the information unless permitted or required by those laws.
III. Rights and Expiration:
I understand that I may revoke this authorization at any time, except to the extent that ASH or TPA has taken action in reliance on this authorization. If I revoke this authorization, SHA may not be able to evaluate my application for coverage and/or claim. To revoke this authorization, I must provide a written and signed revocation to ASH at the address or fax number above. Unless otherwise revoked, this authorization shall remain in effect for two (2) years from the date signed or upon my death, whichever occurs first. I agree that a copy of this authorization is as valid as the original and that I or an authorized representative may request a copy of this authorization.
IV. Notice:
I understand that ASH is not conditioning payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that if the information disclosed is protected health information relating to a health plan and the person or entity receiving the information is a not a health care provider or health plan covered by federal privacy regulations, the information disclosed may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.

- If records are on an adult dependent, (e.g. spouse, child over 18), the dependent must sign this form
- If records are on a minor child the natural parent or legal guardian must sign on their behalf.