Needs Request Form

Complete this form if you:

- Paid out of pocket for ELIGIBLE shareable medical expenses and wish to submit those medical costs to the health share for reimbursement
- Were admitted to the hospital and wish to request the Indemnity allowance that is part of yourmembership (if applicable)

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. My signature on this form indicates that I have read and understand the fraud notice included in this request.

Primary Member's Signature:	Date:
Patient's Signature:	Date:

Primary Member Information

First Name:	Last Name:	MI:	Gender:	SSN:	
DOB:	Phone:	Email:			
Street:	City:	State:	ZIP:		
Employer's Name, if Employer Group:	Member ID Number:	Membership Group:			

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

Patient Information

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

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

If yes, provide the date of the injury.

Describe how the injury occured.

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?
(Please 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.

Dates of Service	Physician Name	Address	City/State/ZIP	Phone

Primary Treating Physician Information			
Physician Name:	Address:	City, State, ZIP:	Phone:

Was the patient confined to the hospital as a result of this condition? ○ No ○ Yes

1.If you were hospitalized as a result of this event, please include a copy of the hospital bill indicating your diagnosis and number of days hospitalized.

2.If the member is over 19 and a full time student, please enclose proof of admission from the institution's registrar.

3.In order to document the contents of this form member must sign the completed Needs Request form.

4.HIPAA authorization form must be signed for the request to be reviewed.

Send Needs Request form and supporting documentation to:

Alliance for Shared Health
Attn: Needs Request Processor
3155 Sutton Blvd. Suite 201
St. Louis, MO 63143

Fax: 314 - 594 - 0600 Attn: Member Services

or

Scan and Email to: Info@ashcommunity.org

Please allow up to 60 days for review and processing of this request.

Authorization to Obtain Information

Primary Member's Name:	SSN:	Date of Birth:
Member ID #:		
Address:		
Name of Individual Subject to Disclosure (If not the primary Member):		Date of Birth:

Relationship to Primary Member:

◯ Self ◯ Spouse ◯ Domestic Partner ◯ Child ◯ Stepchild ◯ Grandchild

I. Authorization:

For the purpose of evaluating my eligibility for assistance and sharing allowances 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 request 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 party 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 needs 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 sharing in needs per membership guidelines. 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 sharing of needs on whether I sign this authorization. I understand that if the information disclosed is protected health information relating to a health share membership 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

(Print Patient's Name) _____

(Print Primary Member's Name) _____

(Patient's Signature) _____

(Primary Member's Signature) _____

(Date signed) _____

(Signature of ASH representative) _____