Prescription Reimbursement Request

Medi-Share®

Complete one form per family member if you (the member) have paid out of pocket for medical treatment(s) or procedure(s) and are requesting reimbursement for eligible medical needs per the Medi-Share Guidelines. Members are responsible for submitting all information.

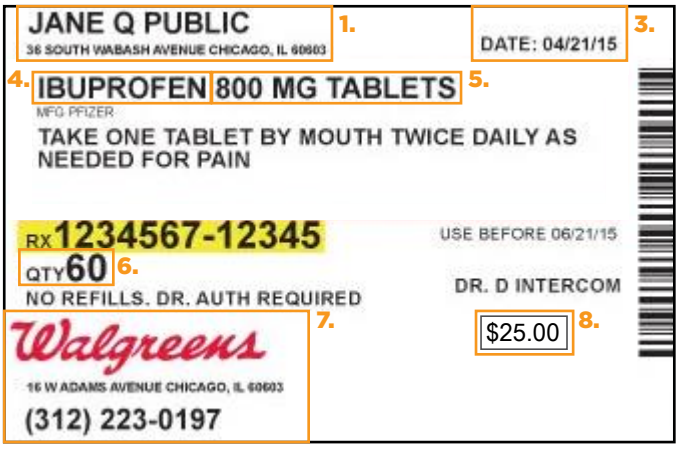
Instructions

Do not complete for ineligible needs (GL VI:J) or bills that have already been applied to your Annual Household Portion (AHP). Bills must be received within 1 year from the Date of Service. All eligible submissions will be applied towards any unmet AHP and then shared as outlined per the Medi-Share Guidelines.

1. Fill out the Member Request for Reimbursement form on page 2 of this document.
2. Check that all documents are legible and contain ALL information listed in the example below. This information is necessary for your need to be considered for sharing. If your submission is missing any of the information below, you will receive an email listing the missing information. Incomplete submissions will be ineligible for sharing until complete information is received.
3. Submit the Prescription Reimbursement Request form and a COPY of the RX Slip(s) (prescriptions only) (GL VI:I) using the following methods:
   - Mail: Christian Care Ministry, PO Box 120040, West Melbourne, FL 32912
   - Fax: 321-722-5138
   - Email: memberservices@MyChristianCare.org All email submissions must be sent as a .PDF or .JPG
4. Timeframe for Prescription Reimbursement: 30 Days

RX Slip from Pharmacy Must Include the Following

1. Patient Name
2. Doctor's Name
3. Date Prescription Filled
4. Medication Name
5. Dosage
6. Day Supply/Quantity
7. Pharmacy Name and Address
8. Total Charge/Paid



Sample only. Prescriptions can be filled at any pharmacy.

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Personal Information *(please print clearly)*

HEAD OF HOUSEHOLD		HOUSEHOLD ID NUMBER
ADDRESS		
CITY	STATE	ZIP+4
HOME PHONE	MEMBER/PATIENT NAME THAT INCURRED EXPENSES	

Pharmacy Information *(one form must be submitted for each)*

PHARMACY NAME

Medication Name	Condition Medication is Treating	Date of Diagnosis (MM/DD/YY)	Date Filled (MM/DD/YYYY)	Total Charge Amount	Total Discount	Total Paid

Please email this completed form along with the requested documents/receipts to **memberservices@mychristiancare.org**, fax to **321-722-5138**, OR mail to: **Christian Care Ministry, PO Box 120040, West Melbourne, FL 32912**