기독의료상조회
CHRISTIAN MUTUAL MED-AID
Since 1996
Owned by Logos Missions, Inc.
5235 N. Elston Ave. | Chicago, IL 60630 | Phone 773.777.8889 | Fax 773.777.0004 | www.cmmlogos.org

NEEDS PROCESSING REQUEST FORM

PRIMARY NAME (주회원 이름)	LAST NAME (성)	FIRST NAME (이름)	MIDDLE NAME	CMM ID # (회원 번호)	
PATIENT (환자 이름)	LAST NAME (성)	FIRST NAME (이름)	MIDDLE NAME	GENDER (성별) ☐ M ☐ F	DATE OF BIRTH (생년월일) / /
ADDRESS (주소)	ADDRESS (주소)	APT. #	CITY (도시)	STATE (주)	ZIP CODE (우편번호)
PHONE # (전화번호)	HOME PHONE # (집전화)	CELL PHONE # (휴대전화)	WORK PHONE # (직장전화)	EMAIL ADDRESS (이메일)	
CHURCH (교회)	CHURCH NAME (교회이름)		PASTOR NAME (담임 교역자 이름)	CHURCH PHONE # (교회전화)	
DIAGNOSIS (진단)	DATE SYMPTOMS BEGAN (증상 시작일)		DIAGNOSIS (의사 진단명)		

MATERNITY ONLY (출산만 해당)

EXPECTED DUE DATE (출산예정일)	ACTUAL DATE OF BIRTH (출산일)	CHILD NAME (자녀이름)	CHILD GENDER (자녀성별)
/ /	/ /		☐ M ☐ F

* PLEASE ATTACH THE DOCUMENT OF EXPECTED DUE DATE OR BIRTH CERTIFICATION.

PLEASE CHECK(√) YES OR NO FOR EACH OF THE FOLLOWING (해당 사항에 각각 'YES' 또는 'NO'에 표시(√)하시오.)

	QUESTIONS FOR MEDICAL COSTS 의료비 지불 내용에 대한 질문	ANSWER 예/아니오	IF YOU CHECK 'YES', PLEASE CHECK(√) FOR EACH OF THE FOLLOWING. 만일 '예' 하였다면, 해당 신청 프로그램에 표시(√)하시오.
1	I HAVE PAID FOR ALL OF MY MEDICAL BILLS FOR THIS INCIDENT. 본인은 의료비 전체를 지불하였습니다.	YES NO	☐ PATIENT (환자) ☐ PERSONAL INSURANCE (보험) ☐ FINANCIAL AID (병원보조) ☐ PUBLIC AID (정부보조) ☐ MEDICARE (메디케어) ☐ MEDICAID (메디케이드) ☐ KIDS CARE ☐ ETC. _____
2	I HAVE PERSONALLY PAID FOR SOME OF MY MEDICAL BILLS FOR THIS INCIDENT. 본인은 의료비 중 일부를 지불하였습니다.	YES NO	☐ PATIENT (환자) ☐ PERSONAL INSURANCE (보험) ☐ FINANCIAL AID (병원보조) ☐ PUBLIC AID (정부보조) ☐ MEDICARE (메디케어) ☐ MEDICAID (메디케이드) ☐ KIDS CARE ☐ ETC. _____
3	I HAVE APPLIED FOR FINANCIAL ASSISTANCE WITH THE HOSPITAL ASSISTANCE PROGRAM / GOVERNMENT PROGRAM. 본인은 의료비 보조를 위해 병원 또는 정부 보조 프로그램을 신청하였습니다.	YES NO	☐ FINANCIAL AID (병원보조) ☐ MEDICARE (메디케어) ☐ MEDICAID (메디케이드) ☐ KIDS CARE ☐ PUBLIC AID (정부보조) ☐ ETC. _____
4	I HAVE REQUESTED 'SELF-PAY' / UNINSURED / PROMPT PAYMENT DISCOUNTS FROM MY MEDICAL PROVIDERS. 본인은 해당 의료기관에 할인을 요청하였습니다.	YES NO	☐ ALL (전체) ☐ SOME (일부) ☐ NONE (없음)

I understand that CMM members send money for one another out of a desire to share each other's burden. Therefore, it would be an abuse of their trust if I use the money received for share needs for some other purpose. I understand that if I do I will not be eligible to partciapate in the ministry nor will be able to publish additional needs. In addition, I understand that Christian Mutual Med-Aid may negotiate reduction on my behalf with my medical provider.
본인은 기독의료상조회의 회원들이 다른 이들의 짐을 나누기 위해 서로 도움을 주고 있음을 이해합니다. 그러므로 회원들이 보내주는 돈은 의료 경비외에 다른 용도로 사용할 수 없음을 확인합니다. 만일 다른 용도로 사용했을 경우에는 기독의료상조회 회원을 계속할 수 없으며 의료비 지원이 되지 않음을 확인합니다. 기독의료상조회는 본인의 의료비 지불을 위해 의료진들과 의료비 조율을 함을 이해합니다.

Any submitted needs will not be shared regardless of the date of the medical bill due to membership cancellation or termination (with the exception of death) (CMM Guidelines, Section III, D). Furthermore, whether or not you receive any payments for medical expenses and whether or not CMM continues to operate, you are always responsible for payment of your own medical bills (CMM Guidelines, Section III, D).
회원 자격이 종료 혹은 취소되었을 경우에(사망은 예외), 진료 날짜에 관계 없이 귀하가 이미 신청한 의료비는 지원되지 않을 것입니다. 나아가 의료비 지원 유무나 CMM의 의료비 처리 유무에 관계 없이, 회원 본인의 의료비 청구서에 대한 지불 책임은 언제나 회원에게 있습니다.(CMM 가이드라인 Section III, D)

X _____ Signature of Patient Individual (환자 서명)

X _____ Print Name of Patient Individual (환자 이름)

/ / Date (날짜)

X _____ Representative's Legal Authority to Individual (환자 또는 보호자 서명)

X _____ Print Name of Authorized Representative (환자 또는 보호자 이름)

/ / Date (날짜)

* ALL 4 PAGES MUST BE COMPLETED AS INCOMPLETE FORMS WILL DELAY PROCESSING TIME. (까지 꼭 작성해야 합니다. 불충분한 서류는 의료비 처리 기간을 지연시키게 됩니다.)
* PLEASE ALLOW US 30 TO 60 DAYS TO PROCESS THE NEEDS (30~60일안에 처리될 수 있도록 협조해 주십시오.)

OFFICE USE ONLY

INCIDENT	①	②	③	RECEIVED
NOTES				

Updated 2018/10/15

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EXPLANATION OF CONDITION AND PRAYER REQUEST FORM

MEMBER QUALIFICATION 회원자격 요건	**Did you accept Jesus Christ as Lord and Savior?** ☐ YES ☐ NO 당신은 예수 그리스도가 당신의 구세주이심을 믿습니까? **Are you a tobacco or nicotine user?** ☐ YES ☐ NO 흡연을 하십니까? **Are you alcohol dependent?** ☐ YES ☐ NO 음주를 하십니까?
PLEASE BRIEFLY STATE THE CIRCUMSTANCES OF THIS ACCIDENT OR INCIDENT (1) START DATE (2) SYMPTOMS (3) PROCESSING TREATMENTS AND TESTS	질병과 관련하여; (1) 질병 발생 시기, (2) 증상, (3) 검사 및 치료과정 등을 기록하십시오.
ADDITIONAL NOTE	제출한 의료비와 관련하여 중요한 설명이 필요할 때에 기록하여 주십시오.
PRAYER NOTE	기도 내용을 적어 주십시오.

※유의사항

(1) 의료기관을 이용한 날로부터 반드시 6개월 안에 의료비 청구 관련 서류들을 제출해 주십시오.
(2) CMM에 연락하지 않고 치료받은 의료비에 대해서는 40%를 공제한 60%의 의료비만 지원됩니다.

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CMM 기독의료상조회
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HEALTH INFORMATION RELEASE AUTHORIZATION FORM

** All fields in RED are required.*

--- SECTION A ---	
* NAME:	* DATE OF BIRTH: MM / DD / YYYY
* ADDRESS:	* CMM #:
* CITY: ST: ZIP:	* TELEPHONE:
* LAST 4 DIGITS OF SOCIAL SECURITY NUMBER: X X X - X X -	

I understand that Christian Mutual Med-Aid is a not-for-profit health care sharing ministry that coordinates assistance for its members' eligible medical bills. Christian Mutual Med-Aid 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 release my protected health information to Christian Mutual Med-Aid to negotiate medical bills on the undersigned's or dependent's behalf.

I further authorize, Christian Mutual Med-Aid, to discuss any and all health information related to my records described in this authorization with 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 released:

- ☐ Complete Health Record
- ☐ History & Physical Exam
- ☐ Abstract/Pertinent Information
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Emergency Department Record
- ☐ Progress Notes
- ☐ Laboratory Tests
- ☐ Radiology Reports
- ☐ All records regarding all bills, billing codes, diagnosis codes, and other billing information
- ☐ Other: _____

--- 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 may not be revoked where Christian Mutual Med-Aid has reasonably acted in reliance upon this authorization.
- This authorization is voluntary and I may revoke the authorization in writing addressed to the Privacy Officer at 5235 N. Elston Ave., Chicago, IL 60630.
- 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.
- Payments of treatment, enrollment or eligibility for cost sharing may not be conditioned on execution of this authorization.
- A copy of this form, including facsimile and e-mail, may be used in place of the original.

_____ * Signature of Patient Individual

_____ * Print Name of Patient Individual

_____ * Representative's Legal Authority to Individual

_____ * Print Name of Authorized Representative

* Date: _____

FAILURE TO COMPLETE AND SUBMIT THIS FORM WILL RESULT IN DELAYED PROCESSING

HIPAA COMPLIANT AUTHORIZATION FORM

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NEEDS PROCESSING WORKSHEET

의료기관이 발행한 항목별 **"의료비 내역서 (ITEMIZED BILL)"**의 원본과 함께 보내십시오.

ITEMIZED BILLS are required for all submitted needs.

	Date of Service (진료일시)	Medical Provider/Pharmacy (진료받은 병원/의사, 병원, 처방약 등)	Original Amounts (원 의료비 금액)	Discounts (할인)	Paid Amounts (지불여부)	Balance (잔여액)	Applied for discounts or financial aid (할인신청)
	1/2/2018	UNIVERSITY MEDICAL CENTER	$ 4,200.00	($ 1,200.00)	$ 1,000.00	$ 2,000.00	(Y) / N
1.			$	($)	$	$	Y / N
2.			$	($)	$	$	Y / N
3.			$	($)	$	$	Y / N
4.			$	($)	$	$	Y / N
5.			$	($)	$	$	Y / N
6.			$	($)	$	$	Y / N
7.			$	($)	$	$	Y / N
8.			$	($)	$	$	Y / N
9.			$	($)	$	$	Y / N
10.			$	($)	$	$	Y / N
11.			$	($)	$	$	Y / N
12.			$	($)	$	$	Y / N
13.			$	($)	$	$	Y / N
14.			$	($)	$	$	Y / N
15.			$	($)	$	$	Y / N
16.			$	($)	$	$	Y / N
17.			$	($)	$	$	Y / N
18.			$	($)	$	$	Y / N
19.			$	($)	$	$	Y / N
		TOTAL	**$**	**($)**	**$**	**$**	

SEND COMPLETED NEEDS PROCESSING FORMS TO: **CHRISTIAN MUTUAL MED-AID**
ATTN: NEEDS PROCESSING DEPT.
5235 N. ELSTON AVE.
CHICAGO, IL 60630

CONTACT US:
Toll Free **773-777-8889 (5003)**
Fax **773-777-0004**
E-mail **npd**@cmmlogos.org

Updated 2018/10/15