Christian Healthcare Ministries
chministries.org | 1.800.791.6225 | 330.848.1511
Hours of operation:
Monday – Friday | 9:00am – 5:00pm EST

Reimbursement Agreement Affidavit

INSTRUCTIONS: Please complete the following form so that CHM may process your medical bills in accordance with the CHM Guidelines.

PATIENT INFORMATION

County: _____ State: _____ Date of accident: _____ / _____ / _____

Patient name(s): _____ Member #: _____

By signing below, I/we, do hereby agree that upon receipt of monies from Christian Healthcare Ministries (CHM) for payment of medical bills incurred and/or related to incident that occurred on the date listed above and upon final litigation or settlement receive payment from Medicare, Worker's Compensation, insurance or receive adjustments and/or write-offs refunded to me after CHM shared the bill in full, or funds from any other entity, I/we agree to transfer to CHM any and all amounts recovered from any sources arising out of the incident, up to the amount of benefits payments shared and paid for by CHM on behalf of the Member (or Member's Dependent) if applicable. This does not include life insurance, disability or income protection insurance, or dismemberment or loss of eye or limb insurance.

_____ _____
Signature Date

NOTARY INFORMATION

Notary public of: _____ Recorded in: _____
(state) (county)

Name: _____ Commission: _____

_____ _____
Signature Date

Return to: Christian Healthcare Ministries
Attn: Member Bill Processing
127 Hazelwood Ave.
Barberton, OH 44203
330.848.1511
800.791.6225 TOLL FREE
chministries.org