CMM 기독의료상조회
Since 1996
CHRISTIAN MUTUAL MED-AID
Operated by Logos Missions, Inc.

NEEDS PROCESSING REQUEST FORM

※ CMM is a health care sharing ministry, not a substitute for medical insurance.

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(√) ALL, SOME OR NONE FOR EACH OF THE FOLLOWING.

	QUESTIONS FOR MEDICAL COSTS 의료비 지불 내용에 대한 질문	ANSWER 전체/일부/없음			IF YOU CHECK 'YES', PLEASE CHECK(√) FOR EACH OF THE FOLLOWING. (해당 사항에 각각 'ALL', 'SOME' 또는 'NONE'에 표시(√)하시오.)
		ALL	SOME	NONE	
1	I HAVE PAID FOR ALL OF MY MEDICAL BILLS FOR THIS INCIDENT. 본인은 의료비를 지불하였습니다.				☐ PATIENT (환자) ☐ PERSONAL INSURANCE (보험) ☐ FINANCIAL AID (병원보조) ☐ PUBLIC AID (정부보조) ☐ ETC. _____
2	I HAVE APPLIED FOR FINANCIAL ASSISTANCE WITH THE HOSPITAL ASSISTANCE PROGRAM / GOVERNMENT PROGRAM. 본인은 의료비 보조를 위해 병원 또는 정부 보조 프로그램을 신청하였습니다.				☐ FINANCIAL AID (병원보조) ☐ PUBLIC AID (정부보조) ☐ ETC. _____

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 due to membership cancellation or delinquency, regardless of the date of the medical bill (with the exception of death) (CMM Guidelines, Section VIII. C, 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 I. C).
회원 자격이 종료 혹은 취소되었을 경우에(사망은 예외), 진료 날짜에 관계 없이 귀하가 이미 신청한 의료비는 지원되지 않을 것입니다.(CMM 가이드라인 Section VIII. C, D)
나아가 의료비 지원 유무나 CMM의 의료비 처리 유무에 관계 없이, 회원 본인의 의료비 청구서에 대한 지불 책임은 언제나 회원에게 있습니다.(CMM 가이드라인 Section I. C)

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. (❶~❹까지 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.

Send To: Christian Mutual Med-Aid | 2315 Sanders Road | Northbrook, IL 60062
Attn.: Needs Processing Department | Tel. 773-777-8889(Ext.5003) | Fax 773-777-0004

Updated 01/2023

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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 알코올에 의존하십니까?
PLEASE BRIEFLY STATE THE CIRCUMSTANCES OF THIS ACCIDENT OR INCIDENT (1) START DATE (2) SYMPTOM (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 1년 내에 의료비 청구 관련 서류들을 제출해 주십시오.
(2) CMM에 연락하지 않고 치료받은 의료비에 대해서는 지원 가능한 의료비는 전체 금액 최대 60% 까지만 지원될 수 있습니다.

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HEALTH INFORMATION RELEASE AUTHORIZATION FORM

SECTION A

** All fields are required. | Type in Enlgish*

* 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 determine eligibility and 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

*** Information to be released: (Check that applies)**

☐ **All Medical Records,** including but not limited to: progress notes, consultation reports, history and physical exam, emergency department records, outpatient/inpatient records, operation reports, discharge summaries, lab results, radiology reports; OR

☐ Only the following records of health information: _____

_____

☐ Billing Records regarding all statements, billing codes, diagnosis codes, and other billing information

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 2315 Sanders Road, Northbrook, IL 60062.
- 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

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NEEDS PROCESSING WORKSHEET

의료기관이 발행한 항목별 "의료비 내역서(ITEMIZED BILL)" 를 제출하여 주십시오. (제출하는 서류의 복사본 1부를 회원의 기록을 위해 반드시 보관하십시오)

Submit the Itemized Bill issued by the Medical Provider when requesting for sharing needs.
(Please keep a copy of ALL submitted documents for your records)

NOTE

1. If a CMM member's voluntary CMM monthly gift remits via direct deposit from the member's bank account, the needs-sharing amount will be directly deposited into the same account.
2. If a CMM member wants to use a different bank account to send their needs-shares to, submit a **void check** to **CMM**.
3. If CMM does not have any of the information above, CMM will mail the check directly to the member.

1. 월기프트를 회원의 은행 계좌 자동이체로 송금하고 있다면 같은 계좌로 의료비 나눔 자동이체
2. 만약 1번의 은행 계좌 이외의 계좌로 자동이체 원하면 **CMM**으로 **Void Check** 제출
3. 1번 혹은 2번의 경우가 아니면 체크 발송

	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)	DISCOUNTS OR FINANCIAL AID (할인신청)
	1/2/2021	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.		**TOTAL**	$	($)	$		

SEND COMPLETED NEEDS PROCESSING FORMS TO:

CHRISTIAN MUTUAL MED-AID
ATTN: NEEDS PROCESSING DEPT.
2315 SANDERS ROAD
NORTHBROOK, IL 60062

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

Updated 11/2022