



## Subscription verification form

We are asking you to fill out this form because we need more information to complete your request.

### Requirements:

- ▶ Try to call for your trip at least **two business days** before your appointment.
- ▶ We must get this form within 45 days after your appointment.
- ▶ You must include all required receipts.
- ▶ We will send your money within 14 days of your appointment after we get your completed form and any required receipts.
- ▶ We may take another 14 days if your request is incomplete.

### Please fill out the member information below:

Member name: \_\_\_\_\_

Health Share Member ID number: \_\_\_\_\_

**Members:** Mail completed forms and required receipts to: P.O. Box 301339, Portland, OR 97294

**Health care providers:** Include a cover sheet with clinic contact details and fax the forms to: 503-296-2681

You can get this document in other languages, large print, braille or a format you prefer. You also have the right to an interpreter. You can get help from a certified or qualified health care interpreter. This help is free. Call 800-224-4840, TTY 711, or tell your provider. We accept relay calls.

**Please fill in the date and day of the week for each of the member's appointments.**

Clinic staff: Please initial each date the member attended appointments or received treatment. Telehealth appointments do not qualify for reimbursement.

**Month:** \_\_\_\_\_ **Year:** \_\_\_\_\_

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Signing this form, I certify that the information given is correct.

Physician/office representative signature: \_\_\_\_\_ Date: \_\_\_\_\_