



Application for the Extra Blessings Gift Program MS 1.0

Members qualifying for Extra Blessings may have their ineligible needs published and distributed to the entire membership with the monthly share statements. Please complete the following information:

Name of Member (please print) _____
Membership No. _____ Phone number: _____
Name of Patient _____
Address _____
Email Address _____

Brief Description of **the condition, the reason the condition was ineligible for sharing and amount owed:**

\$ _____

Qualifications for the Extra Blessings Gifts list are based on the program that you are currently enrolled in. The ineligible need must be more than \$2,500 plus the IMR must be met. Please check the appropriate program.

___ 250 Program IMR ___ 1,000 Program IMR ___ 10,000 Program IMR

Please note, needs that have been denied for sharing based on Section VIII. F. and I. are not eligible for Extra Blessings.

***Reminder: All Explanation of Sharing statements regarding this need must be returned with this application. You must also include all billing from providers to correspond with Explanation of Sharing statements. Your name cannot be placed on the list until we receive this information.** For Adoption related expenses – please submit a copy of the charges from the Adoption Agency or Attorney

Your signature below gives us approval to publish your personal need information. Names will remain on the published list for two consecutive months. Recipients have the responsibility when their need has been met to notify the Extra Blessings Representative at (800) 264-2562 ext. 2367 so their name can be taken off the list. Members receiving more gift funds than needed have the responsibility to give the surplus to other members on the list who are still in need. Please do not submit this application if this need is currently under review or if you plan to request a review in the future. Once you have submitted this application, you have agreed that you will not submit for a review of this need.

Please contact your Member Advocate to complete a Program Eligibility Questionnaire. If an Initial screening determines you may be eligible for a government or benevolent program; we will assist you in getting approval.

Signature: _____ Date: _____