



Non-claim Remit Cost Share Collection Form

Please use this form if you are a Foster Home, Expanded Adult Residential Care Home or Nursing Facility that has collected cost share from a member, in situations where **cost share exceeds claim amount**. It may also be used to remit cost share where the member is a Medicare or other insurance primary, so there may be no Medicaid claim.

Please provide the information below. Also, include a check (payable to 'Ohana Health Plan) for the remaining monthly cost share. For more details, please contact our customer service department at (888) 846-4262.

Provider Name		Provider Number:	
Provider Phone Number		Contact Person (if different than Provider Name)	
Member Name:		Member ID Number:	
*Cost Share Month/Year <small>(Date of cost share month)</small>	Total Cost Share <small>(Monthly cost share determine by the state)</small>	Cost Share Amt. on claim	
Check amount paid to 'Ohana should be the total monthly member cost share (-) cost share amt. on claim (=) Check amount paid to 'Ohana	Check #	Check amount paid to 'Ohana	

Please mail this form and your payment to:

'OHANA HEALTH PLAN
P.O. BOX 75510
CHICAGO, IL 60675-5510

* Please submit one form per member per month of cost share owed

*****FOR PROVIDER USE ONLY*****

(Not to be used by 'Ohana Health Plan Members)
collection form.doc