



Liberty HealthShare Member ID #: \_\_\_\_\_

**From:** Member Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Phone Number: (\_\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**To:** Liberty HealthShare

\* May send via ShareBox (fastest), fax to (216) 456-8115, or email to bills@libertyhealthshare.org

Date of Request: \_\_\_\_\_ (mm/dd/yy)

**Re:** Request for partial reimbursement for my monthly Direct Primary Care (DPC) fee.

I request sharing for my monthly DPC membership fee for the month of \_\_\_\_\_ (mm/yy).

\* Please note that sharing requests will not be honored more than 3 months after the fact

**My Liberty HealthShare membership is:**

(check only 1)

- Individual
- Couple
- Family

**My membership in the DPC applies:**

(check only 1)

- only to me (Individual)
- to me and one other (a couple)
- to my family of 3 or more

This is a request for partial sharing of the monthly DPC membership fee expense that I have already paid to my DPC practice. I understand that the amount that will be shared with me depends in part on the health and financial stewardship services my DPC practice provides to me, per my assessment on page 2 of this form. I understand that such sharing of my monthly DPC membership fees is a voluntary act of other Liberty HealthShare members. There is no assurance that my DPC fees will be shared. **The DPC practice is not involved financially in this sharing request.** Liberty HealthShare may change the monthly DPC fee amount shared by other members with 30 days notice. To be considered for sharing, all requests for DPC membership fee sharing must be submitted by me (the member) within 3 months of my paying the DPC fee. The amount shared with me may vary from month to month based on Liberty HealthShare's assessment of the DPC practice, and based on evolving experience as to how Liberty HealthShare should support membership in DPC practices overall.

DPC practice name: PatriotDirect Family Medicine \_\_\_\_\_

DPC practice city/state: Natick, MA \_\_\_\_\_

**PLEASE GO TO PAGE 2 TO COMPLETE THIS SHARE REQUEST.**



Member Name: \_\_\_\_\_ Liberty HealthShare Member ID #: \_\_\_\_\_

My payment for the DPC fee for this month was \$ \_\_\_\_\_. \* The amount that actually paid to my doctor or to the practice. US Dollars only please.

My DPC practice provides to me the following health and cost savings services (**check each that applies**):

|  |
|--|
| <input checked="" type="checkbox"/> My physician or his/her medical practice is available to me for same day office visits and answers my phone calls within a day.<br><i>* Communication by email, text, or videoconference may count. Your DPC physician should be available so you rarely, if ever, need to use an emergency room for anything other than a true emergency.</i> |
| <input checked="" type="checkbox"/> Access to discounts for any laboratory tests I may need (blood, urine tests, etc.).<br><i>* DPC practices should strive to provide you with access to steep discounts on <b>necessary</b> lab tests.</i>   |
| <input checked="" type="checkbox"/> Discounts for any radiology procedures I may need (x-rays, CT, MRI, ultrasound, etc.).<br><i>* These can be performed within the practice (at a discount or free), or through special deals the DPC practice makes for you with other nearby practices or facilities.</i>  |
| <input checked="" type="checkbox"/> Discounts for any local subspecialist visits or procedures from other doctors I may need.<br><i>* Many practices will not have this, but please encourage them to seek out and nurture such relationships.</i>   |
| <input type="checkbox"/> Availability of prescription and other pharmaceuticals provided directly to you at the doctor's office at low or no cost.<br><i>* This is available in some states. Ask your practice about this.</i>   |
| <input type="checkbox"/> Negotiated discounted fees when I need to access urgent care facilities or emergency rooms.<br><i>* This is a rare but superb service for DPC practices to offer.</i>   |

Please initial the following boxes to indicate your understanding and agreement with the following statements:

- I understand that the DPC fee includes only the set monthly membership fee billed by my DPC practice, not anything else I am billed for that falls outside of the DPC contract.
- I understand that my DPC fees do not apply to my Liberty HealthShare Annual Unshared Amount and that only partial sharing will be provided. I understand that the purpose of sharing in the costs of my DPC membership is to encourage my use of the DPC practice and my avoidance of other, less effective and more expensive ways to access care, whenever appropriate. Except for the occasional true emergency, my first point of contact with the medical system should almost always be through my Direct Primary Care practice.
- If this is my first sharing request for these fees, I have attached a copy of the DPC agreement with my DPC doctor, or a practice brochure. **Note:** Practice information may be requested annually.  
Alternatively, here is the practice's web address: www.patriotdirectfm.com
- All adult Liberty HealthShare members in my household have read and understand the most recent version of the ministry's Sharing Guidelines.

I attest that the above statements are true.

Member Signature: \_\_\_\_\_

**LHS USE ONLY**

LHS VETTED DPC