JOHNS HOPKINS
HEALTH PLANS

For faster turnaround time, fax your claim directly to: 410-424-4664

or

Mail to: USFHP Claims Department
7231 Parkway Drive, Suite 100
Hanover, MD 21076

US Family Health Plan Reimbursement Form

1. Patient Name (Last, First, Middle Initial)	2. Telephone Number Daytime Evening
3. Address (Street, Apt.#, City, State and Zip Code)	4. Member Number
5. Date of Birth (MM/DD/YYYY) 6. Sex ☐ Male ☐ Female	7. Was Patient's Care: ☐ Inpatient ☐ Day Surgery ☐ Outpatient
8. Sponsor's Name	9. Patient's Relationship to Sponsor ☐ Self ☐ Stepchild ☐ Spouse ☐ Other (specify) ☐ Child (natural or adopted)
10. Total Medical Expenses (U.S. currency) finance.yahoo.com/currencyconverter	**11.** Country where services were rendered:

12. Please include the information below (if applicable) to assist in prompt reimbursement.

PROVIDER OF SERVICE

- Proof of payment *(for example: canceled check, credit card receipt, electronic funds transfer receipt)*
- CPT/Procedure codes
- DX/Diagnosis codes
- Date(s) of service
- Provider ID #, Name & Address
- Billed amount for each service

SERVICE PROVIDED OUTSIDE THE LOCAL AREA

- Proof of payment *(for example: canceled check, credit card receipt, electronic funds transfer receipt)*
- Description of services
- Description of diagnosis
- Date(s) of service
- Provider ID #, Name & Address
- Billed amount for each service

13. Signature of patient or authorized person certifies correctness of claim.

Signature: Date: