JOHNS HOPKINS
MEDICINE
US FAMILY HEALTH PLAN

For faster turn-around time, fax your claim directly to
410-424-4664

or

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

Johns Hopkins US Family Health Plan Reimbursement Form

1. PATIENT NAME (Last, First, Middle Initial)		2. TELEPHONE # Daytime ( ) Evening ( )
3. ADDRESS (Street, Apt. #, City, State and Zip Code)		4. MEMBER #
5. DATE OF BIRTH (MM/DD/YYYY)	6. SEX ☐ Male ☐ Female	7. WAS PATIENT'S CARE: ☐ Inpatient ☐ Outpatient ☐ Day Surgery
8. SPONSOR'S NAME		9. PATIENT'S RELATIONSHIP TO SPONSOR ☐ Self ☐ Spouse ☐ Child (natural or adopted) ☐ Stepchild ☐ Other (specify)
10. Total Medical Expenses (US Currency) http://finance.yahoo.com/currency-converter		11. Country where services were rendered:

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

PROVIDER OF SERVICE	SERVICE PROVIDED OUTSIDE THE LOCAL AREA
· Proof of payment *(for example: canceled check, credit card receipt, electronic funds transfer receipt)*	· Proof of payment *(for example: canceled check, credit card receipt, electronic funds transfer receipt)*
· CPT/Procedure Codes	· Description of services
· DX/Diagnosis Codes	· Description of Diagnosis
· Date(s) of Service	· Date(s) of Service
· Provider ID#, Name & Address	· Provider ID#, Name & Address
· Billed amount for each service	· Billed amount for each service

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

Signature: _____ Date: _____