

Submitting a Reimbursement Claim For USFHP

Follow the steps below to complete a Reimbursement Claims Form. Be sure to enter in all the required information and attach proof of payment information to ensure timely processing.

Steps

- 1. Log into your HealthLINK member portal. (If you do not already have an account, click the Member Register button under "First Time Logging In?")
- 2. Once inside your member portal, go to the "My Health Plan" menu and select "**Claims Reimbursement** Form."

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My Health 🔻	My Providers 🔻	My Health Plan 🔻	My Resources 🔻	My Preferences 🔻		
		Benefits & Eligibility				
We	lcome back!	Claims Reimbursement Form				
	Through your HealthLINK@Hopkins account, you are able to review Care Provider (PCP), request a new ID card, manage an electronic Pc		, check the status of a referral d, and so much more.	or claim, select a new Primary		
Stay up-to-date with your personal health information by visiting freq		Claims				
Coronavirus		Member Information				
	Coronavirus <u>Click here</u> for information and updates on Coronavirus (C					
QUICK LINKS	QUICK LINKS INFORMATION FOR YOU					

3. Select the "Member Reimbursement Form" link. Note: You can also check the status of previously submitted claims on this page.

JOHNS HOPKINS					
Welcome,					
Please see below for available	actions				
Submit New Form	Form Status				
Member Reimbursement Form	Your status may tal see your record.	Your status may take up to 30 minutes to appear, while being initially processed. Please check back, if you don't see your record.			
	Confirmation #	Reference #	Message	Status	
	2139148	5395861	Opened: 7/2/2020 - Member Reimbursement	Submitted	
	2139210	5396024	Opened: 7/8/2020 - Member Reimbursement	Submitted	
	2139212	5396025	Opened: 7/8/2020 - Member Reimbursement	Submitted	
	2139217	5396029	Opened: 7/8/2020 - Member Reimbursement	Submitted	



4. If you have dependents on your account, a window with the dependents will show. Select the appropriate member.

Member ID	Subscriber	FALSE	Subscriber	DOB	м	Plan	Select
Member ID	Spouse	FALSE	Spouse	DOB	м	Plan	Select
Member ID	Dependent	FALSE	Dependent	DOB	F	Plan	Select
Member ID	Dependent	FALSE	Dependent	DOB	м	Plan	Select
I			1				

5. In the Claims Reimbursement Form, fill out all the required fields and include any supplemental information. Add your proof of payment as an attachment.

Resource

The table below contains the fields and descriptions found on the Claims Reimbursement Form. You may find it helpful to reference this chart as you fill out the form.

Form Field	Description		
I. Member Information	For whom is this claim being submitted?		
The member information is auto-popu	lated based upon the selected member, (single member or selected		
	ly members). If you select the wrong member from the list of covered		
family members, selecting 'Clear Mem	ber Detail' will return you to the selection grid.		
Member ID	Auto Populated: ID# from the insurance card of the insured.		
First Name	Auto Populated: Member's First name as shown on the insurance card		
Last Name	Auto Populated: Member's Last name as shown on the insurance card		
Health Plan	Auto Populated: Member's Health Plan based upon selected member		
Date of Birth	Auto Populated: Member's date of birth		
2. Member Information			
Was Patient's Care:	Select whether the reimbursement is for inpatient, outpatient,		
	or day surgery.		
Patient's Relationship to Sponsor	What is the relationship of the patient to the sponsor?		
Daytime Phone			
Evening Phone			
Sponsor's Name	Required if 'Self' is NOT selected for the 'Patient's Relationship to		
	Sponsor' field.		
	(field will not show on the form unless an option other than 'Self' is selected		
	for Patient's Relationship to Sponsor)		
Country Services were Rendered	Which country was the care was received in		
3. Requestor Information			
Requestor Name	Auto Populated:		
	Name of individual completing the form (for contact purposes)		
4. Claim Information			
Provider's Tax ID	Optional		
Group/Provider Name	Required: Name of the provider or facility where the service was		
	performed		



Provider NPI#	Optional			
Patient Account#	Optional			
Provider Address Line I				
Provider Address Line 2	Optional: Address where the service was performed			
City, State, Zip				
5. Service Lines Enter each individual procedure as documented on the bill.				
Add lines as needed.				
Date of Service	The date the service was provided			
Billed Amount	The amount billed by the provider or facility			
Procedure Code or Description	The procedure code or description of the service provided			
Diagnosis Code or Description	The diagnosis code or description relating to the service provided			
Number of Service Lines	Auto Populated with the number of service lines on the form			
Amount Paid	The amount paid to the provider to date.			
Total Charge	Auto Populated with the sum of all billed amounts entered.			
6. Attachments				
Click to upload an attachment	Optional; allows you to select an attachment to upload			
Click to Sign Document	This is required as you must enter your signature to certify that, to the			
	best of your knowledge, all the information is valid and correct.			