



**JOHNS HOPKINS**

M E D I C I N E

US FAMILY HEALTH PLAN

Mail to: USFHP Claims Department  
P.O. Box 33  
Glen Burnie, MD 21060-0033  
410-424-4528  
Toll free 800-80-USFHP (7347)

## 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  <input type="checkbox"/> Male <input type="checkbox"/> Female	7. WAS PATIENT'S CARE:  <input type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> Day Surgery	
8. SPONSOR'S NAME		9. RELATIONSHIP TO SPONSOR  <input type="checkbox"/> Self <input type="checkbox"/> Stepchild <input type="checkbox"/> Spouse <input type="checkbox"/> Other (specify) <input type="checkbox"/> Child (natural or adopted)	
10. Total Medical Expenses (US Currency) - <a href="http://www.oanda.com">www.oanda.com</a>		11. Country where services were rendered:	
12. Please attach a copy of the bill, Explanation of Benefits and all information (if applicable) below, to assist in reimbursement.		NOTE: Prescription drugs require the name of the patient; name, strength and quantity of each drug; National Drug Codes (NDC) for each drug (if available); prescription number of each drug; name and address of pharmacy and the name of the prescribing physician.	
<b>PROVIDER OF SERVICE</b>	<b>SERVICE PROVIDED OUTSIDE THE LOCAL AREA</b>		
<ul style="list-style-type: none"> <li>• Receipt(s) of member's payment</li> <li>• CPT/Procedure Codes</li> <li>• DX/Diagnosis Codes</li> <li>• Date(s) of Service</li> <li>• Provider ID#, Name &amp; Address</li> <li>• Referral on file</li> <li>• Billed amount for each service</li> </ul>	<ul style="list-style-type: none"> <li>• Receipt(s) of member's payment</li> <li>• Description of services</li> <li>• Description of Diagnosis</li> <li>• Date(s) of Service</li> <li>• Provider ID#, Name &amp; Address</li> <li>• Missing Referral Type</li> <li>• Billed amount for each service</li> <li>• Country where services were rendered</li> </ul>		

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_