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
☐ Male ☐ Female

7. WAS PATIENT'S CARE:
☐ Inpatient
☐ Outpatient
☐ Day Surgery

8. SPONSOR'S NAME

9. RELATIONSHIP TO SPONSOR
☐ Self
☐ Spouse
☐ Child (natural or adopted)
☐ Stepchild
☐ Other (specify)

10. Total Medical Expenses (US Currency) - www.oanda.com

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.

PROVIDER OF SERVICE

- Receipt(s) of member's payment
- CPT/Procedure Codes
- DX/Diagnosis Codes
- Date(s) of Service
- Provider ID#, Name & Address
- Referral on file
- Billed amount for each service

SERVICE PROVIDED OUTSIDE THE LOCAL AREA

- Receipt(s) of member's payment
- Description of services
- Description of Diagnosis
- Date(s) of Service
- Provider ID#, Name & Address
- Missing Referral Type
- Billed amount for each service
- Country where services were rendered

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.

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

Signature: ______________________________ Date: ________________