Johns Hopkins Employer Health Programs (EHP)
Member Medical and/or Vision Claim Form
Instruction Sheet

Member information:	
Member's Name (Last, First Middle initial): **Enter last, first and middle initial**	*Member's Address (Street, City, State, Zip):* **Enter member's address street, city, state and zip code**

Member's Date of Birth:	*Member's Gender:*	*Member's EHP Member ID#:*
Enter the member's date of birth	**Enter member's gender** ☐Male ☐Female	**Enter member's EHP identification number from their ID card**

Was the condition related to?	*Was this an emergency?*
Answer questions below pertaining to the member's condition B. Member's Employment ☐Yes ☐ No B. Accident ☐Yes ☐ No If yes, when? _____ Where? _____	**Enter if services were performed due to an emergency** ☐Yes ☐ No

Other Health Insurance Coverage *(Policy Holder, Plan Name & Address and Policy or Medical Assistance #)*:
Enter any other health insurance the member is covered under including policy holder name, plan name & address and policy number

Employee information *(if different from member specified above)*:	
Employee's Name (Last, First Middle initial): **Enter last, first and middle initial**	*Employee's EHP Member ID#:* **Enter employee's identification number from their ID card**
Relationship to Member: **Enter the employee's relationship to the member listed above** ☐Spouse ☐ Dependent	*Employee's Group # (or Group Name or FECA Claim #):* **Enter the employee's group ID number from their ID card**

Provider information:	
Provider/Group Name: **Enter the provider or group name**	*Provider's Tax ID and NPI#:* **Enter the provider's tax identification number and national provider identifier number**
Provider's Address *(Street, City, State, Zip):* **Enter the provider's address, street, state and zip code**	*Patient Account # (found on receipt or bill):* **Enter the patient account number from the bill or receipt**

Date(s) of Service	*Procedure Codes/Description*	*Diagnosis* Codes/Description	*Billed Amount*
Enter dates of treatment	**Enter CPT codes and description of procedure**	**Enter ICD-10 codes and description of diagnosis**	**Enter amount billed for treatment**

Amount Paid:	*Balance Due:*	*Total Charge:*
Enter the amount paid to the provider	**Enter the balance due to the provider (should be zero)**	**Enter the total charge for all services**

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Member Medical and/or Vision Claim Form

Mail to: Employer Health Programs
6704 Curtis Court
Glen Burnie, MD 21060

or Fax to: 410-424-4611

Member information:		
Member's Name *(Last, First Middle initial)*:	Member's Address *(Street, City, State, Zip)*:	
Member's Date of Birth:	Member's Gender: ☐Male ☐Female	Member's EHP Member ID#:
Was the condition related to? A. Member's Employment ☐Yes ☐ No B. Accident ☐Yes ☐ No If yes, when? _____ Where? _____		Was this an emergency? ☐Yes ☐ No
Other Health Insurance Coverage *(Policy Holder, Plan Name & Address and Policy or Medical Assistance #)*:		
Employee information *(if different from member specified above)*:		
Employee's Name *(Last, First Middle initial)*:		Employee's EHP Member ID#:
Relationship to Member: ☐Spouse ☐ Dependent		Employee's Group # *(or Group Name or FECA Claim #)*:
Provider information:		
Provider/Group Name:		Provider's Tax ID and NPI#:
Provider's Address *(Street, City, State, Zip)*:		Patient Account # *(found on receipt or bill)*:

Date(s) of Service	Procedure Codes/Description	Diagnosis Codes/Description	Billed Amount

Amount Paid:	Balance Due:	Total Charge:

For additional space, please use the back of this form

Signature: _____ Date: _____

Signature of Member or Authorized Person certifying the correctness of this claim

To ensure prompt reimbursement, please include **proof of payment (for example: cancelled check, credit card receipt, electronic funds transfer receipt)** with your claim submission.