



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

Mail to: Employer Health Programs or Fax to: 410-424-4611  
6704 Curtis Court  
Glen Burnie, MD 21060

Member information:			
Member's Name (Last, First Middle initial):		Member's Address (Street, City, State, Zip):	
Member's Date of Birth:	Member's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Member's EHP Member ID#:	
Was the condition related to?  A. Member's Employment <input type="checkbox"/> Yes <input type="checkbox"/> No    B. Accident <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____ Where? _____			Was this an emergency? <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> Spouse <input type="checkbox"/> 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: \_\_\_\_\_  
*Signature of Member or Authorized Person certifying the correctness of this claim*

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

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



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

<b>Member information:</b>			
<i>Member's Name (Last, First Middle initial):</i> <b>Enter last, first and middle initial</b>		<i>Member's Address (Street, City, State, Zip):</i> <b>Enter member's address street, city, state and zip code</b>	
<i>Member's Date of Birth:</i> <b>Enter the member's date of birth</b>	<i>Member's Gender:</i> <b>Enter member's gender</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<i>Member's EHP Member ID#:</i> <b>Enter member's EHP identification number from their ID card</b>	
<i>Was the condition related to?</i> <b>Answer questions below pertaining to the member's condition</b>  B. Member's Employment <input type="checkbox"/> Yes <input type="checkbox"/> No      B. Accident <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when? _____ Where? _____			<i>Was this an emergency?</i> <b>Enter if services were performed due to an emergency</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>Other Health Insurance Coverage (Policy Holder, Plan Name &amp; Address and Policy or Medical Assistance #):</i>			
<b>Enter any other health insurance the member is covered under including policy holder name, plan name &amp; address and policy number</b>			
<i>Employee information (if different from member specified above):</i>			
<i>Employee's Name (Last, First Middle initial):</i> <b>Enter last, first and middle initial</b>		<i>Employee's EHP Member ID#:</i> <b>Enter employee's identification number from their ID card</b>	
<i>Relationship to Member:</i> <b>Enter the employee's relationship to the member listed above</b> <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent		<i>Employee's Group # (or Group Name or FECA Claim #):</i> <b>Enter the employee's group ID number from their ID card</b>	
<b>Provider information:</b>			
<i>Provider/Group Name:</i> <b>Enter the provider or group name</b>		<i>Provider's Tax ID and NPI#:</i> <b>Enter the provider's tax identification number and national provider identifier number</b>	
<i>Provider's Address (Street, City, State, Zip):</i> <b>Enter the provider's address, street, state and zip code</b>		<i>Patient Account # (found on receipt or bill):</i> <b>Enter the patient account number from the bill or receipt</b>	
<i>Date(s) of Service</i> <b>Enter dates of treatment</b>	<i>Procedure Codes/Description</i> <b>Enter CPT codes and description of procedure</b>	<i>Diagnosis Codes/Description</i> <b>Enter ICD-10 codes and description of diagnosis</b>	<i>Billed Amount</i> <b>Enter amount billed for treatment</b>
<i>Amount Paid:</i> <b>Enter the amount paid to the provider</b>	<i>Balance Due:</i> <b>Enter the balance due to the provider (should be zero)</b>		<i>Total Charge:</i> <b>Enter the total charge for all services</b>