JOHNS HOPKINS
EMPLOYER HEALTH PROGRAMS
sponsored by Johns Hopkins Medicine

Mail to: Employer Health Programs
6704 Curtis Court
Glen Burnie, MD 21060
410-424-4400
Toll free 800-261-2393

MEDICAL and/or VISION CLAIM FORM

1. PATIENT'S NAME (LAST, FIRST, MIDDLE INITIAL)	2. PATIENT'S DATE OF BIRTH	3. EMPLOYEE'S NAME (LAST, FIRST, MIDDLE INITIAL)
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	5. PATIENT'S SEX ☐ MALE ☐ FEMALE	6. EMPLOYEE'S I.D. # (FOR PROGRAM ABOVE) INCLUDE ALL NUMBERS
	7. PATIENT'S RELATIONSHIP TO EMPLOYEE ☐ SELF ☐ SPOUSE ☐ CHILD	8. EMPLOYEE'S GROUP # (OR GROUP NAME OR FECA CLAIM #)
9. OTHER HEALTH INSURANCE COVERAGE (ENTER POLICY HOLDER, PLAN NAME & ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)	10. WAS CONDITION RELATED TO: A. PATIENT'S EMPLOYMENT ☐ YES ☐ NO B. ACCIDENT ☐ YES ☐ NO	11. INSURED'S ADDRESS (IF DIFFERENT THAN PATIENT'S) TELEPHONE # ( ) _____ - _____
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW. ►_____ Sign Date		13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW. ►_____ Sign (Insured or Authorized Person) Date
14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP):	15. DATE FIRST CONSULTED FOR THIS CONDITION:	16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY GIVE DATES:
16.A. IF EMERGENCY ☐ CHECK HERE	16.B. IF INJURY OR ILLNESS DUE TO ACCIDENT, PROVIDE: WHEN? WHERE?	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (E.G. PUBLIC HEALTH AGENCY):		
18. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (IF OTHER THAN HOME OR OFFICE):		
19. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: 1. 2.		

DATES OF SERVICE FROM	TO	PLACE OF SERVICE	FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES, OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE	EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES	CHARGES	DAYS OR UNITS	TOS

20. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREES OR CREDENTIALS). I CERTIFY THAT THE STATEMENTS APPLY TO THIS BILL ARE MADE A PART THEREOF. ►_____ Sign Date	21. YOUR PATIENT'S ACCOUNT #:	22. TOTAL CHARGE:	23. AMOUNT PAID: / 24. BALANCE DUE:
	25. YOUR SOCIAL SECURITY #:	27. PHYSICIAN'S SUPPLIERS, AND/OR GROUP NAME, ADDRESS, ZIP CODE & TELEPHONE #:	
	26. YOUR EMPLOYER I.D. #:	I.D. #:	