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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Mail to: Employer Health Programs 7231 Parkway Drive, Suite 100 Hanover, MD 21076 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	
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 1) Proof of payment (Copy of paid receipt with provider's signature, Front and back copy of cancelled check or electronic posting information, Credit/debit card statement with card type (Visa, Mastercard, etc.), transaction # and/or last 4 digits of card number), 2) Copy of an itemized bill or invoice, 3) Description of services, 4) Description of diagnosis, 5) Billed amount for each service, 6) Provider name, address, Tax ID/NPI#