JOHNS HOPKINS HEALTH PLANS

Member's Request for Medical Reimbursement

Please Print Information

1 Name of Member from ID Card
(Last) (First) (Middle)

SEND COMPLETED FORM TO:
Johns Hopkins Advantage MD Attn: Claims
P.O. Box 3537
Scranton, PA 18505
OR FAX: 1-855-206-9203

2 Member ID Number (found on the front of your ID card)
_____

Sex
☐ Male
☐ Female

3 Mailing Address (City, State, Zip Code) ☐ Check here if this is a new address

(Street or P.O. Box – Please Include Apartment Number)

(City) (State) (Zip)

Telephone Number
(Include Area Code)
(☐☐☐)
☐☐☐-☐☐☐☐

4 Describe the illness or injury for which you received treatment

5
a. Are you 65 or older, currently employed, and covered under an employee health insurance plan? ☐ Yes ☐ No

b. Are you 65 or older (with a spouse who is employed) and currently covered under your spouse's employee health insurance plan? ☐ Yes ☐ No

c. If you have any medical coverage other than Medicare, such as private insurance, employment related insurance, State Agency (Medicaid) or the VA, complete the following:
Name and Address of other insurance, State Agency (Medicaid) or VA office

Policy or Medical Assistance No.

Policyholder's Name:

Note: If you DO NOT want payment information on this claim released, put an (✓) here ☐

6 I CERTIFY THAT THE MEDICAL SERVICE(S) OR ITEM(S) DESCRIBED ABOVE WERE RECEIVED FOR USE BY THE MEMBER LISTED ABOVE, AND THAT I (OR THE MEMBER, IF NOT MYSELF) AM ELIGIBLE FOR MEDICAL BENEFITS. I ALSO CERTIFY THAT THE BENEFITS THAT WERE RECEIVED WERE NOT FOR AN ON-THE-JOB INJURY OR COVERED UNDER ANOTHER BENEFIT PLAN. I RECOGNIZE THAT REIMBURSEMENT WILL BE PAID DIRECTLY TO ME, AND THAT ASSIGNMENT OF THESE BENEFITS TO ANY OTHER PARTY IS VOID.

Member Signature | Date signed

7 Signature of Authorized Representative | Date signed

Relationship to Member: ☐ Durable Power of Attorney for Healthcare ☐ Legal Guardian ☐ Legal Surrogate (PA only)
***A copy of Legal Guardianship documents or Durable Power of Attorney for Healthcare must accompany this form if signed by the Beneficiary's Legal Personal Representative.*

JOHNS HOPKINS ADVANTAGE MD HEALTH MEMBER REIMBURSEMENT CLAIM FORM INFORMATION

Johns Hopkins Advantage MD will pay you directly when you complete this form and attach an itemized bill from your physician or supplier. Your bill does not have to be paid before you submit this claim for payment, but you MUST attach an itemized bill in order for Johns Hopkins Advantage MD to process this claim. Mail your completed claim form and an itemized bill to: Johns Hopkins Advantage MD, Attn: Claims, P.O. Box 3537, Scranton, PA 18505 or fax 1-855-206-9203.

If you have any questions, please call Member Services at:

- PPO Members: 1-877-293-5325 (TTY: 711)
- HMO Members: 1-877-293-4998 (TTY: 711)

Member Services hours of operation are Oct. 1 – March 31, Monday through Sunday, 8 a.m. to 8 p.m., and April 1 through September 30, Monday through Friday, 8 a.m. to 8 p.m.

ATTACH YOUR ITEMIZED BILLS TO THIS FORM

Each itemized bill MUST show all of the following information:

- Date of each service
- Place of each service

Doctor's Office	Independent Laboratory	Outpatient Hospital
Nursing Home	Member's Home	Inpatient Hospital

- Description of each surgical or medical service or supply furnished.
- Charge for EACH service.
- Physician's or supplier's name and address. Many times a bill will show the names of several physicians or suppliers. IT IS VERY IMPORTANT THE PHYSICIAN WHO TREATED YOU BE IDENTIFIED. Simply circle his/her name on the bill.
- It is helpful if the diagnosis is also shown on the physician's bill. If not, be sure you have completed Block 4 of this form.
- Mark out any services on the bill(s) you are attaching for which you have already filed a claim.
- If the member is deceased, please call our Member Services Department for instructions on how to file a claim.
- Attach an Explanation of Benefits notice from another insurer that has paid on this claim if you are also requesting a coordination of benefits payment.

NOTICE

Any person who knowingly and with intent to defraud, injure, or deceive any insurance company, submits a claim or application containing any materially false, deceptive, incomplete or misleading information pertaining to such claim may be committing a fraudulent insurance act which is a crime and may subject such a person to criminal or civil penalties, including fines and/or imprisonment, or denial of benefits.