☐ Please check here for change of mailing address or phone number.

HOUSTON POLICE BENEFIT TRUST

1600 State Street, Houston, Texas 77007
Phone 832-200-3410 Fax 832-200-3470

Supplemental Medical Claim Form

INSURED INFORMATION

Insured Name: ______________________________ SS# XXX-XX-_____ Payroll # ____________

Insured Address: ____
(Street or Box #) City State Zip

Date of Birth: ____________ Daytime Phone # ____________________ Personal Email: ____________________

No City of Houston emails

Primary Insurance Type Limited Network Open Access Consumer Driven Other

Supplement Coverage Contract** Supplemental

*****A copy of the Patient's City of Houston major medical card <u>must</u> be attached to this claim form.***

DEPENDENT INFORMATION (Please complete all information)

Spouse: ______________________________________ Date of Birth: ______________

Child: ______________________________________ Date of Birth: ______________

Child: ______________________________________ Date of Birth: ______________

Child: ______________________________________ Date of Birth: ______________

Child: ______________________________________ Date of Birth: ______________

***Comments**:* ____

____

I authorize release of any medical information necessary to process this claim.

Patient/Authorized Signature: ______________________________ Date: ______________