☐ 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

_____ XXX-XX-____ _____

Insured Name Social Security Number Emp. Number

_____ _____

Insured Address Daytime Phone Number

_____

Insured Date of Birth

Primary Insurance (check one) ☐ **Limited Network Plan** ☐ **Open Access** ☐ **Other** ☐ **Consumer Driven Plan**

Coverage (check one) ☐ Contract** ☐ Supplemental

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

DEPENDENT INFORMATION *(PLEASE COMPLETE ALL ITEMS)*

_____

SPOUSE Date of Birth

_____

CHILDREN Date of Birth

_____

CHILDREN Date of Birth

_____

CHILDREN Date of Birth

_____

CHILDREN Date of Birth

*Comments*_____

_____

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

_____ _____

Patient's or Authorized Signature Date