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# 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 must be attached to this claim form.*

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### **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: \_\_\_\_\_

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**Comments:** \_\_\_\_\_

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

Patient/Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_