

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

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

Supplemental Medical Claim Form

INSURED INFORMATION

Insured Name Social Security Number Emp Number

Insured Address Daytime Phone Number

Insured Date of Birth

Primary Insurance (check one) HMO POS Out-of-Area Other
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

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