TALL TREE ADMINISTRATORS

Medical Claim Reimbursement Form

COMPLETE IN FULL & attach itemized statements for services, cash register receipts are not acceptable.
Form must be signed by the member or patient.

1. EMPLOYEE'S HEALTHCARE IDENTIFICATION NUMBER ._____ EMPLOYER_____
2. EMPLOYEE'S NAME: (PRINT) LAST_____FIRST_____
3. EMPLOYEE'S ADDRESS: STREET (P.O BOX)_____
   CITY_____STATE_____ ZIP _____
4. TELEPHONE NUMBER: (_____)_____
5. PATIENT IS: (CHECK ONE) ❑ EMPLOYEE ❑ FAMILY MEMBER
6. IF PATIENT IS FAMILY MEMBER, GIVE:
   PATIENT'S NAME: LAST_____ FIRST _____
   RELATIONSHIP TO EMPLOYEE:_____
   PATIENT'S BIRTHDATE: MONTH _____ DAY _____ YEAR _____
7. DOES THE PATIENT HAVE OTHER HEALTH COVERAGE? ❑ NO ❑ YES, GIVE:
   NAME OF OTHER INSURANCE COMPANY:_____
   SOCIAL SECURITY NUMBER OF PATIENT:_____
   EFFECTIVE DATE OF COVERAGE: MONTH _____ DAY _____ YEAR_____ TYPE OF COVERAGE: ❑ MEDICAL ❑ DENTAL ❑ VISION
   IF PATIENT IS A CHILD, GIVE PARENTS BIRTHDATE(S): A) MOTHER: MONTH _____ DAY _____ YEAR _____
   B) FATHER: MONTH _____ DAY _____ YEAR _____
8. IS TREATMENT FOR INJURY? ❑ NO ❑ YES, If Yes DATE OF INJURY: MONTH _____ DAY _____ YEAR _____
   WHERE DID INJURY OCCUR? ❑ WORK ❑ HOME ❑ SCHOOL ❑ OTHER
   BRIEFLY DESCRIBE HOW INJURY OCCURRED:_____
   _____
   ARE YOU SEEKING REIMBURSEMENT FOR THE INJURY – ILLNESS THROUGH AN ATTORNEY? ❑ NO ❑YES
   NAME OF ATTORNEY_____
   ADDRESS_____PHONE_____
9. PAYMENT FOR THE ATTACHED BILLS SHOULD BE MADE TO: (CHECK ONE) ❑ THE PROVIDER LISTED ON THE BILL(S) ❑ THE EMPLOYEE

PLEASE NOTE: When submitting this form to Tall Tree Administrators, you authorize the service provider named in the attached bills to release medical and other information to Tall Tree Administrators as needed to receive medical records and verify plan coverage.

10. EMPLOYEE SIGNATURE:_____ DATE: _____

Submit completed form & itemized statements to:

P.O. Box 1807
Draper, UT 84020
Or
Fax claims to: 801-274-8900