
Identification Form
For HPFFA Medical Claims Form
Please complete one claim form per person per submission.

Check which plan applies.

HMO PPO MEDICARE ADVANTAGE PLAN OTHER NON CITY

Member Name: _____ Member Birth Date: _____ XXX-XX-_____
Last 4 digits of members social security #

Member Address: _____ City: _____ State: _____

Check if new address:

Zip Code: _____

Dependents Full Name _____ This Claim is for: _____ Relationship: _____

Employee Spouse Child

Dependents Birth Date: _____ Dependent Step Child

Other _____

Signature: _____ Date: _____
Any person who knowingly and with intent to injure, defraud or deceive any benefit plan, files a statement or Claim containing any false, incomplete or misleading information may be guilty of a criminal offense.

Attach all original receipts to this form. Keep copies of all items submitted
For questions about benefits or How To File A Claim,
Call EPSI at 713-932-8917 or HPFFA at 713-223-9166

How To File A Claim

1. A fully completed Identification form is required each time you submit a claim for yourself or your dependent. This form is necessary to help us identify your claim when it reaches our mail room.
2. Attach receipts/statements from providers to this completed identification form.
3. If you were hospitalized as an in-patient, please submit the itemized hospital bill.
4. If you or a covered dependent has non-city group coverage, attach your Explanation of Benefits statement/receipts to this completed identification form.
5. Keep a copy of all items submitted. All payments issued by Employer Plan Service will be sent directly to you. We will not send payments to any providers.
6. Benefits for a member's covered dependents shall be determined by the same schedule which applies to the member.

Send All Claims to: EMPLOYER PLAN SERVICE, INC.
2180 NORTH LOOP WEST, SUITE 400
HOUSTON, TX 77018
713-932-8917 OR 1-800-447-6588