Tall Tree Administrators
11550 South 700 East Suite 200
Draper, UT 84020

Medical Claim Reimbursement Form

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

Member's Identification Number: _________________________

Member's Name: (print)
Last _________________________First_________________________

Member's Address: Street (P.O Box)____
City_______________________________ State______________ Zip ___________________

Telephone number: (___________) _________________________________

The patient is: (check one) ☐ Member ☐ Family Member

If the patient is a family member:
Patient's Name:
Last_____________________________First____

Relationship to Policy Holder: ____

Patient's birthdate: month ___________ day __________ year __________

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 the patient is a child, give parents birthdate(s):
Mother: Month ____________ Day ___________ Year ____________
Father: Month ____________ Day ___________ Year ____________

Is treatment for the injury? ☐ No ☐ Yes, if yes date of injury:
Month ____________ Day ___________ Year ______________
Where did the 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_______________________

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.

Member Signature: ____
Date: ________________________

Submit completed form & itemized statements to:
P.O. Box 1810
Draper, UT 84020
Or
Fax Claims to 801-274-8900