

HEALTHFIRST TPA

P.O. Box 130217 • Tyler, TX 75713-0217

FOR CONTINUING CLAIMS

**(PLEASE COMPLETE FULLY AND ATTACH THIS FORM TO ALL CONTINUING BILLS AND / OR CORRESPONDENCE)
IF THIS CLAIM IS THE RESULT OF AN ACCIDENT YOU MUST INCLUDE ACCIDENT DETAILS.**

GROUP NAME (Employer) _____ GROUP NO. _____

EMPLOYEE'S NAME _____ SOCIAL SECURITY NO. _____

EMPLOYEE'S ADDRESS _____

Check One: CLAIM IS ON EMPLOYEE CLAIM IS ON DEPENDENT

NAME AND RELATIONSHIP OF DEPENDENT _____

HAS THIS INSURANCE COVERAGE TERMINATED? YES, Date Of Termination _____ NO

COBRA EXTENSION? YES Date _____ NO

REMARKS: _____

SIGNED _____ DATE _____