

**Kaiser Member – Third Party Liability
Healthcare Recoveries Billing Request Form
File Number: T1-094879381**

Please note: Neither a fax nor a mailing will constitute an "urgent" billing request unless an explanation of urgency is provided below.

FAX TO: Healthcare Recoveries
1-502-454-1137

OR

MAIL TO: Healthcare Recoveries
P.O. Box 37440
Louisville, KY 40233-7440

REQUESTER:

Firm: _____ Phone #: () _____ - _____

Address: _____ Fax #: () _____ - _____

Attorney: _____ Request Date: _____

INFORMATION NEEDED TO PROCESS YOUR BILLING REQUEST:

Member Name: _____

1) Member Medical Record #: _____

2) List of Kaiser Facilities and dates of service where treatment was rendered:

_____ DOS: _____

_____ DOS: _____

_____ DOS: _____

3) Date of Injury: _____

4) Injury Description: _____

5) Type of Accident: _____

6) Responsible Party: _____

7) Responsible Party Insurance: _____

IF THIS IS AN URGENT REQUEST, PLEASE EXPLAIN:
