

**Kaiser Northern California Third Party Liability
Healthcare Recoveries Billing Request Form**

FAX: (502) 214-1137
MAIL: Healthcare Recoveries
 P.O. Box 36380
 Louisville, KY 40233-6380

REQUESTOR INFORMATION:

Company/Firm: _____ Phone #: () _____ - _____

Address: _____ Fax #: () _____ - _____

Attorney/Adjuster: _____ Request Date: _____

INFORMATION NEEDED TO PROCESS YOUR BILLING REQUEST:

1) Member Name: _____ DOB: _____

1) Member Medical Record #: _____

2) List of **Kaiser Facilities** where treatment was rendered and **each date of service** (a date range is not acceptable):

_____ DOS: _____

_____ DOS: _____

_____ DOS: _____

Additional dates: _____

3) Did the patient have physical therapy? Y/N Ambulance Transport? Y/NTreatment Outside of Kaiser? Y/N Where? _____

4) Date of Injury: _____ Accident Location: _____

5) Injured Body Parts: _____

6) Type of Accident: _____

7) Responsible/Third Party: _____

8) Third Party Insurance: _____

Mailing Address: _____

Phone/Fax: _____

Adjuster Name: _____

Claim #: _____

10) Accident Details: _____

11) Responsible Party Attorney: _____

Mailing Address: _____

Phone/Fax: _____