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/N
Treatment 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: _____