Kaiser Permanente®
Southern California Division

We are sorry for the delay in producing a billing record. As a primarily prepaid system, Kaiser has not had the automated systems for producing bills rapidly that are common to fee-for-service medical providers. Additionally, Kaiser is currently upgrading its billing systems and related processes. The system upgrade has caused delay in our ability to produce a bill for professional services, and in some cases results in a bill that does not include certain items/services in our charges.

Kaiser is not legally obligated to produce bills. (California statutes assure access to medical records, but do not require the creation of billing records where these are not normally generated or where it is otherwise impractical to do so.) Nonetheless, we are trying to produce bills in response to requests to the extent practicable.

Unfortunately, at this time, we are not able to produce a statement of charges for any radiology (x-ray, MRI, MRA, mammograms, etc.) and laboratory work, due to compliance and or regulatory restriction. We apologize for any inconvenience this has cause to you and your client

Sincerely,

NOTICE OF THIRD PARTY LIEN
Third Party Liability Case Processing

TO: Unisource Discovery

Please fax inquiries to:
Third Party Liability Unit
Fax Number: (626) 381-3150
Attention: TPL Account Processing

The purpose of this letter is to provide reliable guidelines when requesting billings and other information for Third Party Liability (TPL).

To establish a Third Party Liability account, please fax the following documents to the Third Party Liability Unit to the fax number provided above:

- Letter of Representation or Kaiser Permanente's Third Party Liability Questionnaire
- The list of the initial dates of services that were a result of the injury, which includes paid outside services and ambulance claims
- HIPAA compliant Medical Release – Please be advised that if Kaiser Permanente does not have a signed HIPAA Medical Release form this may cause a delay in processing your request

Kaiser Permanente has a lien on amounts its member recovers against a third party or its insurer for injuries sustained. (See document titled "Medical and Hospital Service Agreement, which provides you with the applicable portion of the Third Party Liability section). Health Plan has designated Southern California Permanente Medical Group and Kaiser Foundation Hospitals to recover its claim against the third party recovery.

Lastly, once the patient's case has been discharged, please complete and fax the following documents to the Third Party Liability Unit to the fax number provided above:

- A Letter of Discharge stating the patient has finished treatment for the specific date of injury
- The list of all Dates of services that were a result of the injury

Upon receipt of the remaining Date of Services Listing, the patient's case will be processed and you will receive the following information within approximately 30 days, if applicable:

- Consolidated Statement for all Hospital Encounters
- Consolidated Statement for all Professional Encounters
- Consolidated Statement for all Paid Claims and Pharmacy Charges

Sincerely,

Special Recovery Unit – Third Party Liability Unit
Central Business Office
1-888-512-6217, Ext 42196
Monday–Friday, 8 a.m.–4 p.m.

6C. Reductions. The benefits of Members are subject to the following reductions:

(1) Injuries of Illnesses Caused or Alleged to be caused by Third Parties. Members are required to pay for Services, as follows:

(a) Services Rendered at Facilities Contracting with Health Plan. If any injury or illness is caused or alleged to be caused by any act or omission of a third party, services and other benefits are furnished or arranged by Physicians and Hospitals at Non-Member Rates. Payment of these charges is the Member's responsibility, except that the Member is not required to pay any portion of such charges which is in excess of the total amount that the Member (or his or her estate, parent or legal guardian) receives from or on behalf of the third party on account of such acts or omissions, whether by settlement or judgment. Payment shall be made from the proceeds of the settlement or judgment, and Health Plan (or its designee's) shall have a lien on the settlement or judgment for that purpose. At Health Plan's (or its designee's) request the Member (or his or her estate, parent or legal guardian) shall execute a lien form(s) directing his or her attorney or the third party to make payments to Health Plan (or its designee). If Health Plan institutes legal action to enforce its lien, the Member must reimburse Health Plan for the reasonable costs of collection, including attorney's fee.

(b) Emergency Services Received at Facilities Not Contracting with Health Plan. If any injury or illness is caused or alleged to be caused by any act or omission of a third party, payments under Sections 11-S and 12-S are made for the services of physicians, hospitals and other providers not contracting with Health Plan; however, the Member must reimburse Health Plan for any amount paid by Health Plan up to the total amount that the Member (or his or her estate, parent or legal guardian) receives from or on behalf of the third party on account of such acts or omissions, whether by settlement or judgment. Reimbursement is the Member's responsibility and shall be made from the proceeds of the settlement or judgment, and Health Plan (or its designee) shall have a lien on the settlement or judgment, for that purpose. At Health Plan's request the Member (or his or her estate, parent or legal guardian) shall execute a lien form(s) directing his or her attorney or the third party to make payments directly to Health Plan (or to its designee). If Health Plan institutes legal action to enforce its lien, the Member must reimburse Health Plan for the reasonable costs of collection, including attorney's fees.

The provisions of this Section 6-C (1) apply even if the total amount of the Member's recovery on account of the third party's conduct is less than the Member's actual damages.

The Member further agrees that he or she (or his or her estate, parent or legal guardian) will notify Health Plan of any actual or potential claim or legal action which the Member anticipates bringing or has brought against any third party arising from the alleged acts or omissions not later than 30 days subsequent to submitting or filing a claim or legal action against the third party.

Medicare Member Covered by Motor Vehicle Insurance Policy. When Hospitals has provided services to a Medicare Member of Part A Member for any injury or illness described in Section 6-C(1) (a) above, Hospitals will, in compliance with federal law, seek reimbursement under the medical expense payment provisions of any motor vehicle insurance policy covering the Member. Each such Member must furnish information about the existence and terms of any such policy, and complete and submit all claims, releases and other documents necessary for Hospitals to comply with federal law.

PATIENT BUSINESS SERVICES QUESTIONNAIR

(Third Party Liability Information)

NORTHERN CALIFORNIA
❑ HEALTH CARE RECOVERIES, INC. P.O. BOX 37440 LOUISVILLE, KY 40233-7440 1-800-552-8314

SOUTHERN CALIFORNIA

ANAHEIM ❑ 1011 SOUTH EAST ST. ANAHEIM, CA 92805 (714) 284-6888 FAX (714) 284-6725

LOS ANGELES ❑ P.O. BOX 27990 LOS ANGELES, CA 90027-0990 (323) 783-7900

BAKERSFIELD ❑ P.O. BOX 12099 BAKERSFIELD, CA 93389-1299 (661) 864-3358

PANORAMA CITY ❑ 13652 CANTARA ST. PANORAMA CITY, CA 91402 (818) 375-2761

BALDWIN PARK ❑ 1011 BALDWIN PARK BL. BALDWIN PARK, CA 91706 (626) 851-7155

RIVERSIDE ❑ PALM COURT 11 17284 SLOVER AVE. #201 FONTANA, CA 92337 (909) 609-3131

BELLFLOWER ❑ 12200 BELLFLOWER BL. DOWNEY, CA 90242 (562) 622-4208 or 4177

SAN DIEGO ❑ 3250 WING STREET SAN DIEGO, CA 92110 (619) 221-6099

FONTANA ❑ PALM COURT 11 17284 SLOVER ... 01

WEST LOS ANGELES ❑ 6041 CADILLAC AVE. LOS ANGELES, CA 90034 (323) 857-2135

SOUTH BAY ❑ 25825 S. VERMONT AVE. HARBOR CITY, CA 90710 (310) 517-2681

WOODLAND HILLS ❑ 5601 DE SOTO AVE. WOODLAND HILLS, CA 913 (818) 719-2673

PATIENT INFORMATION

PATIENT'S LAST NAME | FIRST | MI | DATE OF BIRTH / /

HOME ADDRESS | CITY | STATE | ZIP CODE

PATIENT'S HOME TELEPHONE NUMBER ( ) | PATIENT'S WORK TELEPHONE NUMBER ( ) | KAISER PERMANENTE MEDICAL RECORD NUMBER | SOCIAL SECURITY NUMBER - -

INJURY OR ILLNESS INFORMATION

DATE OF INJURY / / | ❑ MOTOR VEHICLE ❑ WORK RELATED ❑ INJURY OR OTHER LOCATION ❑ ____________

POLICE REPORT FILED? ❑ YES ❑ NO | POLICE DEPARTMENT | PARTS OF BODY INJURED

CASE PROCESSING INFORMATION

NAME OF EMPLOYER OR PERSON CAUSING ACCIDENT | ADDRESS | CITY | STATE | ZIP CODE

THEIR INSURANCE COMPANY NAME | CLAIM FILED? ❑ YES ❑ NO Claim No. ________ | THEIR INSURANCE COMPANY ADDRESS | TELEPHONE NUMBER ( )

NAME OF EMPLOYER CONTACT OR CLAIMS ADJUSTER

IF PERSON CAUSING ACCIDENT WAS UNINSURED, PLEASE RETURN DMV CERTIFICATE SR-19 OR OTHER VERIFICATION.

OTHER PARTIES ATTORNEY INFORMATION | NAME | ADDRESS | CITY | STATE | ZIP CODE | TELEPHONE NUMBER ( )

PATIENT'S ATTORNEY INFORMATION | NAME | ADDRESS | CITY | STATE | ZIP CODE | TELEPHONE NUMBER ( )

ADDITIONAL INFORMATION

MEDICAL TREATMENT INFORMATION

LIST ALL KAISER PERMANENTE LOCATIONS WHERE YOU RECEIVED TREATMENT FOR THIS ACCIDENT

LOCATION	DATE	LOCATION	DATE
	/ /		/ /
	/ /		/ /

DID YOU RECEIVE EMERGENCY CARE AT A NON-KAISER PERMANENTE FACILITY? ***IF YES, LIST FACILITY NAME AND DATE(S) OF TREATMENT***
❑ YES ❑ NO

DID KAISER PERMANENTE REFER TO A NON-PLAN PROVIDER? ***IF YES, LIST PROVIDER NAME AND (DATES) OF TREATMENT***
❑ YES ❑ NO

HAS YOUR TREATMENT FOR THIS ACCIDENT BEEN COMPLETED?
❑ YES ❑ NO ***If No, please contact us at (800) 933-0224 when treatment is finished so we may complete the final billing.***

AUTHORIZATION TO RELEASE TO

RELEASE TO | REASON FOR RELEASE

ADDRESS | CITY | STATE | ZIP CODE

❑ I hereby authorize KAISER FOUNDATION HOSPITALS, TPMG and/or SCPMG to furnish the above named individual or company all medical data they may request (including X-ray and laboratory reports) concerning my illness or injury.

❑ I hereby authorize KAISER FOUNDATION HOSPITALS, TPMG and/or SCPMG to furnish the above named individual or company all medical data regarding diagnosis, care and treatment for alcohol abuse or drug abuse or mental health from ____________ to ____________.

Indicate limitations, if any, of medical information to be released and/or restrictions, if any, of how such information is to be used ____

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in the reliance hereon, and if not earlier revoked it shall terminate six months from the date of consent without express revocation.

DATE | PATIENT'S SIGNATURE | PARENT OR LEGAL GUARDIAN | RELATIONSHIP

NS-8797 (11-07)
HIPAA COMPLIANT

WHITE-BUSINESS SERVICES | CANARY-PATIENT, PARENT OR LEGAL GUARDIAN

Kaiser Foundation Health Plan
Attention: Third Party Liability Unit - Account Processing
Fax No. (626) 381-3150

Third Party liability Case Processing Request

☐ Initial Date of Service Listing ☐ Final Date of Service Listing

Patient's Name:
Medical Record No.:
Date of Accident:

Please list of the dates of services that were a result of the injury and fax to the number listed above. Kaiser Permanente encourages that the patient keeps a record of all dates of services related to the injury.

Name of Hospital of Service	Date of Service	Type of Service (Dr., ER, PT, RADIOLOGY)

KAISER PERMANENTE®

Kaiser Foundation Hospitals
Southern California Permanente Medical Group

Special Recovery Unit

1 888 512-6217 x 42196

Fax: 1 626 381-3150

8:00 am to 4:00 pm

IMPRINT KAISER PERMANENTE ID CARD HERE

AUTHORIZATION FOR RELEASE AND / OR DISCLOSURE OF MEDICAL INFORMATION

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization.

Please **REQUEST** Medical Information **FROM:**

Special Recovery Unit-Third Party Liability Unit
Parsons East-2nd Floor
393 E. Walnut St.
Pasadena, Ca 91109-9977

Attn: Third Party Liability Unit

Please **SEND** Medical Information **TO:**

Name of Person or Entity to Receive Information

Title (Physician, Therapist, Attorney)

Street Address

City, State and Zip Code

I hereby authorize ____________________ to release and / or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.

Release and / or disclose records and information regarding:

Name of Patient (List Other Names Used) | Medical Record Number | Date of Birth

Address | City | State | Zip Code | ( ) Telephone Number

DURATION: This authorization shall become effective immediately and shall remain in effect until __________(*enter date*) or for one year from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

REDIS-CLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

SPECIFY RECORDS TO BE RELEASED AND / OR DISCLOSED: **Check the box and initial which type of information is to be released and / or disclosed:**

- ❑ **General Medical Information** *(from______ to_____)*
- ❑ **Information Regarding Specific Injury or Treatment** *(from______ to_____)*
- ❑ **X-Ray (check one or both):** ❑ **Films** ❑ **Reports**
- ❑ **Laboratory Results**
- ❑ **Mental Health** *(from_____ to_____)*
- ❑ **Alcohol / Drug** *(from_____ to_____)*
- ❑ **HIV Test Results** *(from_____ to_____)*
- ❑ **Other (specify):** ____________________

Signature of Patient or Patient's Representative | Date

Signature of Patient or Patient's Representative | Date

Signature of Patient or Patient's Representative | Date

I request that the health information released and / or disclosed pursuant to this authorization be used for the following purposes only: ____________________

A copy of this authorization is valid as an original.
I have the right to receive a copy of this authorization. The copy is for me to keep.

Date | Signature of Patient or Patient's Representative | Indicate Relationship (if Signed by Other than Patient)

Southern California Permanente Medical Group
Kaiser Foundation Hospitals

THIRD PARTY LIEN

Health Plan Member:
Date of Injury:
Member's Attorney:
Insurance Company:

Your Medical and Hospital Service Agreement contains a Reductions clause for injuries or illnesses caused by third parties. This clause is reproduced on the reverse side of this form.

It means that the care you or a family member received from, or was paid for by Kaiser Permanente as a result of your injury/illness must be paid for at non-member rates, but **only** if there was a recovery from a Third Party connected with the accident. You do not owe anything (except supplemental charges, if any) unless money is recovered from a Third Party involved in the accident. If less than the amount of the bill is recovered, you are not required to pay the full bill.

Remember, Health Plan has a lien claim on any amounts recovered from Third Party. This means it has a legal right to that recovery in order to collect the amount due. If has designated Southern California Permanente Medical Group and Kaiser Foundation Hospitals to administer and collect its lien claim.

KAISER FOUNDATION HEALTH PLAN, INC.

TO: Kaiser Foundation Health Plan, Inc.

I have read the Third Party Lien, and have read and understand the terms of the Reductions Clause in my Medical and Hospital Service Agreement, printed on the reverse side of this form. I hereby authorize and direct my attorney, the Third Party or the Third Party's insurer to pay Southern California Permanente Medical Group and Kaiser Foundation Hospitals the amount of the charges for the hospital and medical services and other benefits provided in connection with my injury/illness. If I have no attorney or if my attorney, the Third Party or the Third Party's insurer does not make payment, I will be directly responsible for payment of the charges.

I further understand that my failure to pay the amounts due at the time of settlement or judgment is a violation of my Medical and Hospital Service Agreement, and may result in legal action and/or termination from the Health Plan.

______________________________ MEMBER'S SIGNATURE   ______________ DATE

______________________________ ATTORNEY'S SIGNATURE   ______________ DATE