

KAISER MEMBER – THIRD PARTY LIABILITY

**HRI BILLING REQUEST FORM**

**Please Note: Neither a fax nor a mailing will constitute an “urgent” billing request unless an explanation of urgency is provided below.**

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FAX TO: HEALTHCARE RECOVERIES, INC. (502) 454-1191

MAIL TO: HEALTHCARE RECOVERIES, INC.  
P.O. BOX 37740, LOUISVILLE, KY 40233

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**REQUESTOR:**

Firm: \_\_\_\_\_ Ph #: \_\_\_\_\_

Address: \_\_\_\_\_ Fax #: \_\_\_\_\_

Attorney: \_\_\_\_\_ Request date: \_\_\_\_\_

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**INFORMATION NEEDED TO PROCESS YOUR BILLING REQUEST:**

- 1) Member name: \_\_\_\_\_
- 2) Member Medical Record #: \_\_\_\_\_
- 3) List of Kaiser Facilities and dates of service where treatment was rendered:  
\_\_\_\_\_ DOS: \_\_\_\_\_ PT? \_\_\_\_\_  
\_\_\_\_\_ DOS: \_\_\_\_\_ PT? \_\_\_\_\_  
\_\_\_\_\_ DOS: \_\_\_\_\_ PT? \_\_\_\_\_
- 4) Date of injury: \_\_\_\_\_
- 5) Injury description: \_\_\_\_\_
- 6) Type of accident: \_\_\_\_\_
- 7) Responsible party: \_\_\_\_\_
- 8) Responsible party insurance: \_\_\_\_\_  
Mailing address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
Phone #: \_\_\_\_\_  
Aduster name: \_\_\_\_\_  
Claim #: \_\_\_\_\_
- 9) Accident details: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**\*\*If this request is urgent, please explain why:** \_\_\_\_\_

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