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.

FAX TO: HEALTHCARE RECOVERIES, INC. **(502) 214-1291**

MAIL TO: HEALTHCARE RECOVERIES, INC.
P.O. BOX 36380, LOUISVILLE, KY 40233

REQUESTOR:

Firm: Ph #:
Address: Fax #:

Attorney: Request date:

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 #:
   Adjuster name:
   Claim #:
9) Accident details:

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