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

FAX TO: Healthcare Recoveries
1.502.214.1137
OR

MAIL TO: Healthcare Recoveries
P.O. Box 36380
Louisville, KY 40233-6380

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**REQUESTOR INFORMATION:**

Company/Firm: _____ Phone #:_____
Address: _____
_____ Fax #: _____
Attorney/Adjuster: _____

**INFORMATION NEEDED TO PROCESS YOUR BILLING REQUEST:**
Member Name: _____DOB: _____
Medical Record #: _____
List of Kaiser Facilities & Dates of Service:
_____ DOS: _____

_____ DOS: _____

_____ DOS: _____

_____ DOS: _____
Date of Injury: _____
Injury Description: _____
Type of Accident: _____
Responsible Party: _____
Insured Party: _____
Responsible Party Insurance: _____
Mailing Address: _____
Phone/Fax #: _____
Adjuster Name: _____
Claim #: _____
Accident Details:
_____
_____
_____