

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) 454-1291

**** OR ****

MAIL TO: HEALTHCARE RECOVERIES, INC
P.O. BOX 37440
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	_____
_____	DOS	_____
_____	DOS	_____

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 request is urgent please explain: _____