



THIRD PARTY LIABILITY FORM

HRI BILLING REQUEST FORM
EVENT #

PLEASE NOTE: Neither a fax nor a mailing will constitute an “urgent” billing request unless an explanation of urgency is provided.

FAX TO: HEALTHCARE RECOVERIES, INC. (502) 454-1137

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:

FACILITIES	DATES OF SERVICE
_____	_____
_____	_____

4) Date of Injury: _____

5) Injury Description: _____

6) Type of Accident: _____

7) Responsible Party: _____

8) Responsible Party Insurance: _____

9) Mailing Address: _____

Phone/Fax # _____

Adjuster Name: _____

Claim # _____

10) Accident Details: _____

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

