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

ATTN: DEBORAH RICKETTS

KAISER CALIFORNIA NEW FILE INFORMATION SHEET

REQUESTOR INFORMATION:

Company/Firm: _____ Phone #: 209-575-2901

EXPEDITE DOCUMENT IMAGING INC
1317 OAKDALE ROAD, SUITE 310
MODESTO CA 95355

Fax #: 209-575-2917

Attorney/Adjuster: _____ Request Date: _____

INFORMATION NEEDED TO PROCESS YOUR BILLING REQUEST:

Member Name: _____ DOB: _____

1) Member Medical Record #: _____
2) List of Kaiser Facilities and dates of service where treatment was rendered:
   _____ DOS: _____
   _____ DOS: _____
   _____ DOS: _____
3) Date of Injury: _____
4) Injury Description: _____
5) Type of Accident: _____
6) Responsible Party: _____
7) Insured Party: _____
8) Responsible Party Insurance: _____
9) Mailing Address: _____
   Phone/Fax #: _____
   Adjuster Name: _____
   Claim #: _____
10) Accident Details: _____

_____

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