To whom it may concern:

As you are aware: Healthcare Recoveries represents the above named Health Plan. with regard to its subrogation and/or reimbursement: rights.

In order for Healthcare Recoveries: Inc. to process any request for information or billings from Kaiser, the Healthcare Recoveries Billing Request Form (attached), must be completed in order to fulfill the request.

Completion of this form will help expedite your request by determining if the injured party was an active member with the Health plan at the time of the accident. It will also determine which business office will be processing your request. Billing Request Forms that are partially completed cannot and will not be processed. For your convenience, you may call me at the number listed below anytime between 9am and 5pm EST. You may also fax the completed form to (502) 214-1 137. If you fax the form please put the fo11owing phrase on the fax cover sheet:

ATTENTION: DEBORAH RICKETTS - KAISER CALIFORNIA NEW FILE INFORMATION SHEET.

Please be advised that billing statements require a minimum of 60 (sixty) days to process. A completed form will give us the opportunity to request the bills at the point of the first contact from your office or your representatives' office and would also help us avoid any delays in requesting and providing you with the bills.

Thank you for your prompt attention.

Sincerely,

UNIT Q
800-627-1951

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) 214-1137

—OR—

MAIL TO: HEALTHCARE RECOVERIES, INC
P.O. BOX 36380
LOUISVILLE, KY 40233-6380

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:

____