KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington
Claims Administration
P.O. Box 34585
Seattle, WA 98124

Claims Supporting Documentation Form

SUBMIT ONE FORM PER CLAIM

Patient First Name:_____ **MI:**___ **Last:** _____

Patient Date of Birth:_____-_____-_____ **Member Number:** _____

Provider of Service: _____

Tax ID#:_____ **Date(s) of Service:** _____

Claim Number: (If available)_____ **Claim Charge Amount:** _____

Type of Document Attached:

- ____ **Operative report**
- ____ **Discharge summary**
- ____ **Radiology report**
- ____ **Medical records**
- ____ **Other: (Please list)** _____

Name of Kaiser Permanente Department or Requestor Name: _____

Requestor Phone:_____ **Requestor Fax:** _____

Other Information: _____

PLEASE SEND DOCUMENTATION TO:

Kaiser Foundation Health Plan of Washington
Attn: Claims Administration
P.O. Box 34585 Seattle, WA 98124-0528

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