KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington
Kaiser Foundation Health Plan of Washington Options, Inc.
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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