KAISER FOUNDATION HOSPITAL
BUSINESS SERVICES DEPARTMENT

5601 De Soto Avenue
P.O.Box 4048
Woodland Hills, CA 91364-4084
(818) 719-2673

Third Party Liability (TPL) Frequently Asked Questions

This letter explains the responsibility a Health Plan member has to Health Plan when making a claim against or collecting payment from a "third party"

First, let's look at the procedure involved when a Health Plan member needs medical services, If you are ill or injured, you normally receive medical services from a Kaiser Permanente facility. You may or may not be charged a fee or co-pay according to your Health Plan contract. If you receive emergency services from a facility other than Kaiser Permanente, Kaiser typically reimburses that facility. In either case, you are responsible for your co-pays.

What is Third Party Liability?

If you claim that someone else is responsible for your illness or injury, that person(s) is called a "third party." Depending upon the circumstances, you may decide to make a claim for damages against the third party. For example, if someone else is responsible for an automobile accident in which you are injured and your car is damaged, you or someone representing you might decide to file a claim against that person. Perhaps you are awarded a settlement and/or judgement that pays for the damages to your car and/or your medical expenses.

What Is Your Responsibility?

If you decide to make a claim against a third party for damages you sustained in an accident, you have a contractual obligation to notify Health Plan. Health Plan will provide you with billing information to be used to make a medical claim against the settlement you are entitled to receive from the third party.

What Steps Does Health Plan Take?

When you report your claim to us, Health Plan then will have a "lien" against the settlement or judgement received from the third party or insurance carrier. A lien is a right to collect payment. This means that if the third party makes a payment as a result of a settlement or a judgement, Health Plan is entitled to collect from that payment for the medical services Health Plan provided to you. Health Plan is also entitled to collect for emergency services you received that were paid for by the Health Plan.

How Much Can Health Plan Collect?

The amount Health Plan is entitled to collect from the third party settlement or judgement is (1) the value of the medical services that Health Plan provided for your illness or injury, and/or (2) the amount Health Plan paid on your behalf to outside providers for emergency treatment.

However, Health Plan cannot collect more than the total amount of the settlement or judgement. Keep in mind that your fees for medical services are set according to the Health Plan contract, regardless of whether or not there is a third party involved.

Why This Policy?

This policy helps keep your health Plan dues affordable. The Health Plan was designed to offer quality health care for paying members. You are under no obligation to claim third party responsibility. But if you do, and a payment is made to you from the third party or their insurance carrier, the Health Plan contract states that Health Plan must be reimbursed from the payment for the services Health Plan provided to you.

For More Information:

If you have any questions or need more information please call Kaiser Permanete's Third Party Liability Desk at 818-719-2673. Thank you.

KAISER PERMANENTE

Patient Business Services Questionnaire
(Third Party Liability Information)

5601 De Soto Ave Woodland Hills, CA 91365
(818) 719-2673 phone (818)719-2363 fax

PATIENT INFORMATION

Patients Last Name	First	MI	Date of Birth
Home Address	City	State	Zip Code
Patient's Home Telephone Number	Patients Work Telephone Number	Kaiser Medical Record Number	Social Security Number

INJURY OR ILLNESS INFORMATION

Date Of Injury	☐ Motor Vehicle ☐ Work Related ☐ Injury or Other Location ☐ ____________	
Police Report Filed? ☐ Yes ☐ No	Police Department	Parts of Body Injured

CASE PROCESSING INFORMATION

Name Of Person Causing Accident	Address	City	State	Zip Code
Their Insurance Company	Address	City State Zip		Phone Number
Claims Adjuster		Claim Number		
Patient's Attorney Information				
Additional Information				

MEDICAL TREATMENT INFORMATION

List All Kaiser Permanente Locations Where You Received Treatment For This Accident	Location	Date	Location	Date
	Location	Date	Location	Date

Did You Receive Emergency Care At A Non-Kaiser Permanente a Facility? If Yes, List Facility Name And Dates Of Treatment
☐ Yes ☐ No

Did Kaiser Permanente Refer To A Non-Plan Provider? If Yes, List Provider Name And Dates Of Treatment
☐ Yes ☐ No

Has Your Treatment For This Accident Been Completed?
☐ Yes ☐ No

AUTHORIZATION FOR USE AND / OR DISCLOSURE OF MEDICAL INFORMATION

I hereby authorize the physicians and / or employees of Kaiser Foundation Hospitals and / or Southern California Permanente Medical Group to release medical information as indicated below.

Release medical information to: ****Release information to your attorney or the third party insurance company****

Name Of Receiving Party
Address
City, State, Zip Code

DURATION: This authorization shall become effective immediately and shall remain in effect until __________ (enter date) or for one year from the date of signature if no date entered.

REVOCATION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this Authorization.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

SPECIFY RECORDS: Check box and initial which type of information is to be disclosed:
☐ Medical Information ☐ Psychiatric Information_______ ☐ Drug / Alcohol _______ ☐ HIV Test Results ________

I request that the health information released pursuant to this authorization be used for the following purposes only: ____________________

A copy of this authorization is valid as the original. I have the right to receive a copy of this authorization.

________________________ Date

________________________ Signature of the Patient (Indicate Relationship if Signed By Other Than The Patient)

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BUSINESS SERVICES
5601 DE SOTO AVENUE
WOODLAND HILLS, CA 91365-4084
(818) 719-2673 Fax (818) 719-2363

THIRD PARTY LIEN

Health Plan Member: ______________________________
Date of Injury: ______________________________
Attorney: ______________________________
Insurance Company: ______________________________

Your Medical and Hospital Service agreement contains a Reduction clause for injuries or illnesses caused by third parties. A copy of the clause is attached to this form.

It means that the care you or your family member received from, or was paid for by Kaiser Permanente as a result of your injury/illness must be paid for at non-member rates, but only if there was a recovery from a Third Party connected with the accident. You do not owe anything (except supplemental charges, if any) unless money is recovered from a Third Party involved in the accident. If less than the amount of the bill is recovered, you are not required to pay the full bill: contact the Special Recovery Unit to find out the exact amount due.

Remember, Kaiser Foundation Health Plan has a lien claim on any amounts recovered from a Third Party. This means it has a legal right to that recovery in order to collect the amount due. It has designated Southern California Permanente Medical Group and Kaiser Foundation Hospitals to administer and collect its lien claim.

If you have any questions. please contact the Business Services Department Third Party Liability section. Southern California Permanente Medical Group @ 818-719-2673.

KAISER FOUNDATION HEALTH PLAN, INC.

TO: Kaiser Foundation Health Plan, Inc.

I have read the Third Party Lien, and have read and understand the terms of the Reductions Clause in my Medical and hospital Service agreement, attached to this form. I hereby authorize and direct my attorney, the Third Party or Third Party's insurer to pay Southern California Permanente Medical Group and Kaiser Foundation hospitals the amount of the charges for the hospital and medical services and other benefits provided in connection with my injury/illness. If I have no attorney, and the Third Party or the Third Party's insurer does not make payment directly to Kaiser Foundation Health Plan, Inc. I will be directly responsible for payment of the charges.

I further understand that my failure to pay the amounts due at the time of settlement or judgment is a violation of my Medical and Hospital Service Agreement, and may result in legal action and/or termination from the Health Plan.

______________________________ ______________________________
MEMBER'S SIGNATURE DATE

______________________________ ______________________________
ATTORNEY'S SIGNATURE DATE