State of Illinois
Department of Healthcare and Family Services

# LONG TERM CARE FACILITY
# THIRD PARTY LIABILITY (TPL) PAYMENT TRANSMITTAL

Please provide the information below for each TPL payment received for services also paid by HFS and forward with a refund check to:

Healthcare & Family Services
Bureau of Collections
Third Party Liability Section
P. O. Box 19120
Springfield, IL 62794-9120

FACILITY

Name _____

Provider Number _____

RESIDENT

Name _____

RIN _____

Dates of service covered by the TPL payment _____

Amount of the TPL payment _____

Amount of refund to Department _____

Amount of HFS payment for services covered by TPL payment _____

Reason for refund _____

_____

Name of insuring organization _____

_____

If any questions, please call the Provider Recovery Unit at (217) 785-1418.

Print Form