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