Date

Re: *Patient Name*
Date of Birth
Identification Number

To Whom It May Concern,

PLEASE READ CAREFULLY. THIS IS NOT A FINAL CLAIM DETERMINATION AND ADDITIONAL ACTION IS NECESSARY.

We received your billing for services provided to our insured on _/_/_. Our records indicate that you are a member of the INTERLINK Health Services Transplant Network, therefore you need to submit the bill to the network for repricing. The network will then forward your bill to ___________________ for processing.

Please submit the claim to the following address:

INTERLINK Health Services, Inc.
Attn: Transplant Claims
4660 NE Belknap Court, Suite 209
Hillsboro, OR 97124

We will process the claim upon receipt from the transplant network. Please contact Elizabeth Grafton at INTERLINK at (800) 599-9119, Ext. 225 if you have any questions.

Sincerely,