Health Partners Plans

Request for Access to Protect Health Information

Use this form to allow you or your personal representative to request access to obtain and/or inspect Protected Health Information that Health Partners Plans maintains.

INSTRUCTIONS FOR COMPLETING THIS ACCESS FORM

Part 1: Member information. This section should name the Health Partners Plans (HPP) member whose health information will be shared with and/or disclosed to the authorized person/organization. Print the member's name, birth date, address on file, telephone number, and Member ID number.

Part 2: How you would like us to meet this request. This section should indicate how you would like Health Partners Plans meet your request for access to your health information. Under HIPAA, a health plan can charge a fee for copying and mailing records. Additionally, HPP may charge an additional fee if you ask for a summary or copies of your claims information that is over 300 pages.

Part 3: Information requested. HPP maintains claim information related to visits to a provider, hospital and/or other medical facility. The list provided in this part of the form includes the type(s) of claims information available. Check the box related to the claims information you are requesting. If you check "other", tell us what specific information you are requesting. Please indicate the dates for the information requested. (**NOTE: HPP does not create or keep medical records. For example, medical chart, x-rays, test results, etc. Please contact the provider(s) for this information**).

Part 4: Review and approval. The *member's* signature is required. If the member is incapable of signing, a personal or legal representative may sign on the member's behalf. Parents or guardians of minors will be confirmed using information from the state. A Personal Representative such as an executor or someone with power of attorney may sign his or her name in the member's place. The legal documents proving the authority of the personal representative on behalf of the member **MUST** be attached or on file at HPP; otherwise the personal representative's signature will be invalid and this form will **NOT** be processed.

Complete ALL sections. If information on this form is not complete Health Partners Plans will return the form and will not approve this request until it is completed in full.

CONTACT INFORMATION

RETURN YOUR FORM(S) TO THE ADDRESS LISTED BELOW

If you have any questions or need assistance in completing this form, call the Member Relations telephone number on the back of your identification card or write to:

Health Partners Plans
HIPAA Privacy Services
901 Market Street, Suite 500
Philadelphia, PA 19107
or
Fax: 267-515-6666

Request for Access to Protect Health Information

Part 1: Please PRINT the requested information below.	
Member Name:	Date of Birth:
Address:	City/ZIP:
Member ID #:	Telephone: ( )

Part 2: Please select your preferred method of meeting this request

☐ Mail to my address above. Please contact me if the request is over 300 pages.
☐ Request an in-person inspection of information at Health Partners Plans
☐ Via secure email to my email address at _____
☐ I will pick up my information in person
☐ Other, specify _____

Note: HPP can **mail** one (1) copy up to 300 pages free of charge or you can inspect your information at Health Partners Plan's headquarters. For claims information over 300 pages you will be charged $0.35 per page. You may request a list or a summary of your claims information. Under HIPAA, a health plan can charge a fee for providing a summary; the fee for providing a summary is $1.42 per page. Instead of a summary, HPP can provide a list of your claims information up to 300 pages free of charge.

Would you like HPP to prepare a summary of these records?

☐ Yes, please provide a summary for a fee of $1.42 per page
☐ No, please provide a list, free of charge

Part 3: Requested Information

a. Please check the box(es) indicating the claims information you are requesting.

☐ Date of Service- the date you went to the provider or medical facility
☐ Provider/Physician/Medical Facility Name
☐ Provider Address & Phone Number (if available)
☐ Type of service- such as: medical care, surgery, consultation, radiology, labs, etc.
☐ Current Procedural Terminology (CPT codes) - numbers assigned for service provided
☐ Out-of-pocket expenses (co-pay)
☐ Pharmacy (prescription, quantity, refills, pharmacy information, out-of-pocket expenses)
☐ Other:_____

Time period (day/month/year or month/year)? From _____/_____/_____ **to**_____/_____/_____

Part 4: Signature

I have read and understand the above information:

Member or personal representative name : _____

Signature:_____

Date:_____

If you are a personal representative, state your relationship to the member.

_____

Note that, if not already provided, we will require verification of the authority of a personal representative such as a copy of a health care, general or durable power of attorney before this request will be considered complete. If this request is made by a parent/guardian, complete the following: Member/participant is a minor ___ years of age. If you are making this request on behalf of a minor child, we may require additional information such as a court order or other documentation that shows custody or other legal document showing the authority of the legal representative to act on the member's behalf before this request is considered complete.