PROVIDENCE Health Plan

Member Request for Access to a Designated Record Set

If you have questions, please contact Customer Service at 503-574-7500 (toll-free 1-800-878-4445; TTY 503-574-8702 / 1-888-244-6642) or via the Web at www.providence.org/healthplans

MEMBER INFORMATION			
MEMBER LAST NAME	MEMBER FIRST NAME	MEMBER MIDDLE NAME	
DATE OF BIRTH __ __ / __ __ / __ __ __ __	MEMBER ID#	GROUP ID#	
STREET ADDRESS			
CITY	STATE	ZIP CODE	PHONE NUMBER

1. I hereby request a copy of the following from my claims & enrollment record.

☐ for the range of dates from __ __ / __ __ / __ __ __ __ to __ __ / __ __ / __ __ __ __

☐ or for a claim dated __ __ / __ __ / __ __ __ __, services provided by _____ (provider name)

☐ information pertaining to _____

2. Include the following:

☐ Enrollment & Eligibility Record

☐ Premium Statement (if applicable)

☐ Claim Record

☐ Correspondence

☐ Supporting documentation (e.g. medical records, case management, etc.)

☐ Other (specify)_____

3. I understand there are fees to copy my record unless this request is specifically related to an appeal of an adverse decision by Providence Health Plan. The copies I am requesting will cost a flat fee of $25.00. I agree to these charges and have enclosed check or money order for that amount.

4. Signature of member or person completing this form. Please sign and date.

_____ _____
Member or Representative's signature Date

_____ _____
Printed Name of Representative (if applicable) Relationship to Member

5. I specifically authorize the release to me of the following, if such are a part of my record. Please initial to include:

_____ HIV/AIDS _____ Chemical Dependency _____ Mental Health _____ Genetic Testing

_____ _____
Member or Representative's signature Date

_____ _____
Printed Name of Representative (if applicable) Relationship to Member

FOR OFFICE USE ONLY

Date received: __ __ / __ __ / __ __ __ __ Request Review Date: __ __ / __ __ / __ __ __ __ Reviewed by:_____

Action taken: ☐ Request mailed or given to member on __ __ / __ __ / __ __ __ __

Review Requested by: ☐ Chief Medical Officer ☐ Manager ☐ Other: _____

☐ Denied on __ __ / __ __ / __ __ __ __ Reason_____ By:_____

Comments:_____

Transaction completed by:_____ Date: __ __ / __ __ / __ __ __ __