Providence
Medicare Advantage Plans

Information about Your Request to Access Your Protected Health Information (PHI)

What does the right to access PHI mean?

You or your personal representative have the right to inspect, review or get a copy of the information kept by Providence Medicare Advantage Plans in the designated record set in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). The designated record set is a group of records maintained by or for your plan, including certain records used to make decisions about you as a member. This set may include records pertaining to enrollment, claims, case management, medical management, or utilization management.

What do I need to understand to use this right?

- Your access to your records may have legal limits, such as in relation to health information not subject to the right to access information under HIPAA.
- You do not have a right to access PHI that is not part of the designated record set.
- You may not be entitled to receive all of your PHI. For example, you will not receive information such as psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding.
- Calls are recorded for quality and training purposes only. Providence Medicare Advantage Plans is not required to transcribe or produce a recorded call.
- Providence Medicare Advantage Plans will take reasonable efforts to produce the designated record in the format you have requested. However, if Providence Medicare Advantage Plans cannot readily produce the records in the format requested, a mutually agreeable alternative will be established.
- ***For copies of your medical records, call your provider's office.***
- **Appeals and Grievances:** you may request a copy of the documentation collected/created by Providence Medicare Advantage Plans to respond to an appeal or grievance, free of charge by calling Customer Service at the toll free number listed on your Providence Medicare Advantage Plans HealthCare ID card.
- If you are requesting the access for a minor, federal and state laws may prohibit Providence Medicare Advantage Plans from acting upon any request for information relating to sensitive services unless written authorization is received from the minor member.

How much will this cost me?

- The hard copies you are requesting will cost a flat fee of $10.00.
- The electronic (email) copies you are requesting will be free.
- If you wish to pick up or view on site, it will be free.
- If you wish to have records on a CD, it will cost a flat fee of $6.50.

How will I know if my request is processed?

Providence Medicare Advantage Plans will respond to this request within 30 days. If we cannot respond within 30 days, we will send you a written notice describing why it will take longer and the date by which your request will be fulfilled. In certain cases, Providence Medicare Advantage Plans may deny your request. If we deny your request, we will tell you in writing and let you know if and how you can appeal our decision.

How do I ask for access?

Enclosed is the Member Request to Access Protected Health Information (PHI) you requested. Please complete the entire form, sign it and return it to Providence Medicare Advantage Plans. You may send your Member Request to Access to Providence Medicare Advantage Plans at:

Providence Medicare Advantage Plans
Attn: Customer Service
PO Box 5548
Portland Oregon 97228-5548

You may fax your Member Request to Access form to 503-574-8608 or you may hand deliver it (if mailing, use only the post office box address listed above) to the following address:

Providence Medicare Advantage Plans
3601 SW Murray Blvd. #10
Beaverton Oregon 97005-2359

If you have any other questions or concerns, you may contact the Providence Medicare Advantage Plans Customer Service Team at 503-574-8000 or 1-800-603-2340. If you are hearing impaired and use a Teletype (TTY) Device, please call our TTY line at 711. Customer Service assistance is available to answer questions, seven days a week, between 8 a.m. and 8 p.m. (Pacific Time).

Thank you,

Providence Medicare Advantage Plans
Enclosure

Providence
Medicare Advantage Plans

Member Request to Access Protected Health Information (PHI)

Use this form to request a copy of your PHI in a Designated Record Set that Providence Medicare Advantage Plans or one of its Business Associates maintains. If you need assistance completing the form, please contact the Providence Medicare Advantage Plans Customer Service number listed on your member identification card. You must complete all the fields on this form.

PART A: MEMBER INFORMATION		
Member Last Name	**Member First Name**	**Middle Initial**
Member Date of Birth	**Member Identification Number (See your member ID card)**	**Group Number (See your member ID card)**
Member Street Address	**City and State**	**ZIP Code**

PART B: DELIVERY OF THE REQUESTED INFORMATION

I request to review protected health information (PHI) about me in a designated record set held by Providence Medicare Advantage Plans. By placing, an "X" in the appropriate box below, please indicate who will receive your information. Send my PHI to: (**select only one**)

☐ Me at the address listed above (If email is selected below in PART C, Providence Medicare Advantage Plans will not mail to the address above.)

☐ I request that Providence Medicare Advantage Plans send my PHI, as specified in Part D, to the designated third party listed below.

Name	**Address**	
City and State	**Zip Code**	**Phone Number**

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PART C: FORMAT/MANNER OF THE REQUESTED INFORMATION

By placing, an "X" in the appropriate box below, please indicate in which format/manner you wish to receive/review your information. Send my PHI: (**select only one**)

☐ Send paper copies of my records, identified below in Part D, via US certified mail.

☐ Send electronic copy of my records, identified below in Part D, via email. Note: Information will be sent to the email address provided below by secure (encrypted) email unless otherwise specified.

Email address: _____

If you prefer the e-mail be sent unencrypted, please initial here: _____

☐ Send electronic copy of my records, identified below in Part D, via a CD. Note: CD will be sent to the address provided above (encrypted) unless otherwise specified.

If you prefer the CD be sent unencrypted, please initial here:_____

(Warning: Some level of risk may be associated with sending your PHI via unencrypted emails or CDs as they could be accessed and read by unauthorized third parties.)

☐ I want to pick up my records, identified below in Part D, in person, during regular business hours at the Providence Medicare Advantage Plans office. I understand that I or my personal representative will be contacted to arrange for this.

☐ I want to view in person. I understand that I or my personal representative will be contacted to arrange for this.

PART D: DETAILS OF PHI REQUEST

I request the protected health information (PHI) contained in the following records. Please place an "X" next to the items you are requesting.

☐ **Enrollment & Eligibility Information**

Date(s) of Enrollment: _____

Details of request: _____

☐ **Claims Information, including Pharmacy (Summary of claims paid or denied)**
(This does not include information on claims received but not yet processed – if you would like the status of those claims you may call Customer Service at the toll free number listed on your HealthCare ID card.)

Date(s) of Service: _____

Provider(s):_____

Details of Request:_____

☐ **Case or Medical or Utilization Management Information (Prior Authorization)**

Date(s) of Service: _____

Provider(s): _____

Details of Request: _____

☐ **Customer Service Inquiry (CSI)**

Date(s) of Call: _____

Details of Request: _____

☐ **Mental Health (Summary of claims paid or denied)**
(If you check this box, please initial mental health below)

Date(s) of Service: _____

Provider(s): _____

Details of Request: _____

I specifically authorize the release of the following sensitive information, if such are part of my record, and will only be disclosed if I place my initials in the applicable space next to the type of information to be included with the disclosure. *I understand that my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations.

(Initial all that apply):

_____AIDS or HIV

_____Alcohol/Drug/Substance Abuse (Diagnosis, treatment or referral information) *

_____Genetic Information (services or tests)

_____Maternity/Pregnancy (Reproductive Health)

_____Mental Health Data and Records

_____Sexually transmitted illness/disease (testing and treatment)

☐ **Other Information**

Date(s) of Service: _____

Provider(s):_____

Details of Request: _____

PART E: MEMBER SIGNATURE AND DATE

By:_____ Date:_____
(Member Signature)

- OR –

By:_____ Date:_____
(Member's Designated Legal Representative/Guardian Signature)

Relationship to member: ☐ Parent ☐ Legal guardian* ☐ Holder of Power of Attorney*

***If this form is signed by someone other than the member or Parent, please attach legal documentation if you are the legal guardian or Holder of Power of Attorney.**

- ***Note: To parents/legal guardians of minors: state laws may prohibit Providence Medicare Advantage Plans from acting on your request about Sensitive Information without written authorization from the minor member. (Both parent and minor must sign.)***

Providence
Medicare Advantage Plans

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-800-603-2340 (TTY: 711). Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-800-603-2340 (TTY: 711). Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-800-603-2340 (TTY: 711)。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-800-603-2340 (TTY: 711)。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-800-603-2340 (TTY: 711). Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-800-603-2340 (TTY: 711). Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-800-603-2340 (TTY: 711) sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-800-603-2340 (TTY: 711). Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-800-603-2340 (TTY: 711)번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-800-603-2340 (TTY: 711). Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-800-603-2340 (TTY: 711). سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-800-603-2340 (TTY: 711) पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-800-603-2340 (TTY: 711). Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portugués: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-800-603-2340 (TTY: 711). Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-800-603-2340 (TTY: 711). Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-800-603-2340 (TTY: 711). Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするため に、無料の通訳サービスがありますございます。通訳をご用命になるには、1-800-603-2340 (TTY: 711) にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。