Request a copy of personal health information

PacificSource HEALTH PLANS

Need help or have questions? Contact us at the number listed on the back of your member ID card. Your member ID and group numbers are also located on your member ID card.

Last name _____ First _____ Middle _____

Date of birth _____ Member ID no. _____ Group no. _____

Address _____ Email _____

City _____ State _____ Zip _____ Phone _____

I request a copy of the following health information:

☐ for the range of dates from _____ to _____, or

☐ for the claim dated _____, ☐ services provided by _____ (provider)

☐ information pertaining to _____

Including the following:

☐ Claim record ☐ Correspondence ☐ Enrollment and eligibility record

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

☐ Premium statement (if applicable) ☐ Other (specify) _____

I specifically authorize the release to me of the following information, if it is part of my records. (Place your initials next to the items you want included.)

_____ HIV/AIDS _____ Chemical dependency _____ Genetic testing _____ Mental health

I understand the copies I am requesting will cost a flat fee of $25.00 unless this request is specifically related to an appeal of an adverse decision by PacificSource Health Plans. I agree to this charge if it applies.

☐ $25 enclosed. ☐ $0 enclosed. Request is related to an appeal of an adverse decision.

Signature of member or person completing this form:

Signature of member or representative _____ Date _____

Printed name of representative (if applicable) _____ Relationship to member _____

For office use only

Date received _____ Request review date _____ Date _____

☐ Approved on _____ ☐ Record set mailed or given to member on _____

Review requested by ☐ Medical Director ☐ Manager ☐ Other _____

☐ Denied on _____ Reason _____ By

Comments _____

Transaction completed by _____ Date _____