REQUEST ACCESS TO A DESIGNATED RECORD SET

Last name: _____ **First:** _____ **Middle:** _____

Date of Birth: _____ **Member ID No.:** _____ **Group No.:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____ **Phone:** _____

1. I hereby request a copy of the following from my claims and enrollment record:
   - ☐ for the range of dates from _____ to _____, or
   - ☐ for the claim dated _____, services provided by _____ (provider)
   - ☐ information pertaining to _____
2. Include the following:
   - ☐ Claim Record ☐ Correspondence ☐ Enrollment and Eligibility Record
   - ☐ Supporting documentation (e.g., medical records, case management, etc.)
   - ☐ Premium statement (if applicable) ☐ Other (specify) _____
3. I understand there are fees to copy my records unless this request is specifically related to an appeal of an adverse decision by PacificSource Health Plans. The copies I am requesting will cost a flat fee of $25.00. I agree to these charges and have enclosed a check or money order for that amount.
4. Signature of member of person completing this form:

   _____ _____
   Signature of Member or Representative Date

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

5. I specifically authorized the release to me of the following, if such are a part of my record. (Please initial to have them included.)

   _____ HIV/AIDS _____ Chemical Dependency

   _____ Genetic Testing _____ Mental Health

   _____ _____
   Signature of Member or Representative Date

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

FOR OFFICE USE ONLY

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

☐ 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 _____