

## Request for access to protected health information

You have a right to access and inspect the personal information that EmblemHealth and UnitedHealthcare maintain and use to make decisions about your benefits. The Health Insurance Portability and Accountability Act (HIPAA) calls this your protected health information (PHI) that is maintained in a Designated Record Set (DRS). This DRS includes enrollment information, claim requests for payment, claim payments, case or medical management records, appeals, complaints files and other records that are used in whole or in part to make decisions about your benefits.

**You can request information only about yourself** unless you are legally authorized to get information about another individual.

In an effort to make this information more understandable to you, we can provide you with a report that summarizes your eligibility, claims and treatment authorization information as far back as six years from the date of your request. Please be aware that if you ask for this summary and no claims have been processed for your treatment in the past six years, we may only be able to supply you with your eligibility records. If you request this eligibility, claims and treatment authorization summary now and later decide that you want supplemental information, you can request additional information at that time. If you need more detailed information now, you may request it.

When completing this form, please:

- Complete all sections entirely
- Print information clearly
- Provide us with your most current information

Indicate the type of records you are requesting on the attached form, and the dates for which you want that information. Again, please be aware that the furthest back we can provide you with information is six years.

We will respond to requests from a personal representative authorized by a member to receive their PHI (e.g., parent, court-appointed representative, family member). However, we may require additional documentation from the member or the member's personal representative to verify their authority to act on the member's behalf.

Please note that we will only supply you with PHI regarding benefits administered by EmblemHealth, UnitedHealthcare or their affiliates. To obtain your PHI concerning other benefits not managed by EmblemHealth, UnitedHealthcare or their affiliates, you must contact the entity that administers those benefits directly. If we are unable to send you a copy of your PHI within 30 days from the date we receive your request, you will be contacted and advised about the delay.

# Request for access to protected health information

Use this form to request access to your protected health information (PHI) from EmblemHealth and UnitedHealthcare. Complete this form in its entirety (front and back) to ensure your PHI can be located and released. Once the request is approved, a copy of your PHI will be mailed to you or your authorized personal representative.

## Protected health information requested for

Name \_\_\_\_\_ Street address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Phone number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Date of birth     /     /     Gender: Male Female Non-binary Other (specify) \_\_\_\_\_  
MM DD YYYY  
Relationship to subscriber: Self Child If other, describe relationship \_\_\_\_\_

## Type(s) of information requested

Please choose one of the three options below to indicate what type(s) of information you would like to receive:

**(Option 1)** I would like a report that summarizes my eligibility, claims and treatment authorization information.

**(Option 2)** I would like the following information (if applicable):

- Eligibility
- Claims payment and adjudication information
- Treatment authorizations
- Care and treatment coordination of my benefits
- Appeals and complaints I have filed

**(Option 3)** I have previously requested a summary report of my eligibility, claims and treatment authorization information and would like more detailed information about the following claims or treatment authorizations:

Claim number(s) \_\_\_\_\_

Authorization number(s) \_\_\_\_\_

Information requested (relating to these specific claims or authorizations):

- Detailed claims payment and adjudication information
- Care and treatment coordination information (specify): \_\_\_\_\_
- Appeals and complaints I have filed

## Date range of information requested

I would like this information for the following dates:

From six years prior to the date of this request

From     /     /     to     /     /      
MM DD YYYY MM DD YYYY

Please remember we cannot provide information older than six years from the date of your request.

## Date range of information requested (continued)

An authorized signature of the individual, or authorized signature of the personal representative of the individual, who is requesting the PHI is required:

**I authorize the release of my PHI to me at the address stated in Section 1 of this form. I understand that this request does not apply to certain health information, including: (1) information that is not received or maintained by EmblemHealth and UnitedHealthcare; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of or for litigation; and (4) other information not available for access under HIPAA.**

Signature of individual \_\_\_\_\_ Date    /   /     
MM DD YYYY

Signature of parent or personal representative (if applicable): \_\_\_\_\_ Date    /   /     
MM DD YYYY

Parent or personal representative's name \_\_\_\_\_ Street address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Phone number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Relationship to individual and authority to act for individual: \_\_\_\_\_

**Important:** A personal representative, including a parent, legal guardian or executor of an estate, may be required to supply a copy of legal documentation.

## Subscriber information

NYCE PPO member ID \_\_\_\_\_ Group number \_\_\_\_\_

Subscriber name \_\_\_\_\_ Street address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_ Phone number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

### Please maintain a copy of this authorization.

For EmblemHealth and UnitedHealthcare purposes only

Sent by \_\_\_\_\_ Date    /   /    Location \_\_\_\_\_  
MM DD YYYY

Please return the completed form to: **NYCE PPO Plan**  
P.O. Box 21534  
Eagan, MN 55121

Fax: **888-742-4179**