Access to PHI Request Form

Mail to: Western Health Advantage, Attn: Member Services
2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Fax to: 916.568.0126
Email to: memberservices@westernhealth.com
Attach completed form; Include in Subject Line: Access to PHI Request Form
Questions? 916.563.2250, 888.563.2250 toll-free or 888.877.5378 for TDD/TTY

Member Name (First, Last) _____

Date of Birth _____ WHA ID _____

Address _____

Phone No _____ Email _____

This form will allow a member to inspect or obtain a copy of Protected Health Information (PHI) in the designated record set, except for certain limited information such as psychotherapy notes, information WHA has compiled in anticipation of or for use in civil, criminal or administrative actions or proceedings, and certain other records exempted under federal privacy regulations.

Information Requested: (limited to 6 years prior to date of request)

Specific Records from _____ to _____
(Month/Year) (Month/Year)

❑ **Enrollment Records**
- ❑ Application and related documents
- ❑ Coverage and dates of eligibility
- ❑ Change and termination of coverage documents

❑ **Case or Medical Management Records**
- ❑ Medical Management (e.g. utilization review)
- ❑ Case Management
- ❑ Appeals and Grievances
- ❑ Disease Management

❑ **Premium Payment Records**

❑ **Claims or Billing Records**
- ❑ Accumulator
- ❑ Claims History, including Pharmacy

❑ Other Personal Information used or maintained by WHA, specifically: _____

If the information requested will be sent to a designated Third Party, is the recipient also authorized to receive Sensitive Information as described below?

❑ NO ❑ YES If Yes, I specifically authorize WHA to release to Recipient:

❑ All sensitive information OR ❑ Only the following information: (check all that apply)
- ❑ Alcohol/substance abuse ❑ Mental health ❑ Genetic information
- ❑ Sexually transmitted illness (including HIV/AIDS)
- ❑ Sexual, physical, or mental abuse
- ❑ Abortion/reproductive health (including pregnancy, contraception)

Format/Method:

Inspection

❑ I prefer to inspect the requested information in person and will arrange for a mutually convenient time to come to the WHA office

Copy

❑ Paper

❑ Electronic – please specify _____

Please mail to: ❑ Me, at the address: ❑ on record with WHA or ❑ listed in this request

❑ Other/Third Party (Please specify recipient name and complete address):

Name _____

Address _____

❑ I or my personal representative will pick up the copy at the WHA office.

Summary (Check one)

❑ I prefer to receive a written summary of the requested information. Please mail to:

❑ Me, at the address: ❑ on record with WHA or ❑ listed in this request

❑ Other/Third Party (Please specify recipient name and complete address):

Name _____

Address _____

I understand and agree to the following:

- My request will be processed within thirty (30) days, or I will be informed in writing of the need for an extension of not more than 30 additional days to process the request. WHA will take reasonable efforts to produce the designated record in the form and format I requested. However, if WHA cannot produce the records in the form and format requested, a mutually agreeable alternative will be established.
- If I requested for a copy or summary, I will be responsible for paying a reasonable cost-based fee for supplies, labor, postage and copying and the requested information will be mailed to me via US postal mail at the address indicated above.
- This request for access to information may be denied or reduced and only portions released. If so, I have the right to request a review of this decision by a licensed health care professional that WHA designates, by submitting my request in writing to Member Relations, Western Health Advantage, 2349 Gateway Oaks Dr., Suite 100, Sacramento, CA 95833.
- I may file a complaint concerning my request for access to the Privacy Officer, Western Health Advantage, 2349 Gateway Oaks Dr., Suite 100, Sacramento, CA 95833, or to the US Department of Health & Human Services at 200 Independence Avenue, S.W. Room 509F HHH Bldg., Washington, D.C. 20201.
- This request must be accompanied by a copy of a photo ID of the member and the recipient, unless one is already on file with WHA.
- If you send a completed form by email to WHA, you acknowledge that it is not best practice to send protected health information through email that is not secure.

MEMBER NAME (PRINT) MEMBER SIGNATURE DATE

Personal Representative

NAME (PRINT) SIGNATURE DATE

Please check the box that describes your relationship to the member:

❑ Parent of Minor ❑ Legal Guardian ❑ Power of Attorney ❑ Executor ❑ Other

Documentary proof of your relationship/authorization must be attached to this request. If you are requesting the access for a minor 12 years of age or older, federal and state laws may prohibit WHA from acting on your request about information relating to sensitive services without written authorization from the minor.

WHA Internal Use Only

Date Request Received _____ ❑ Identification Verified (documents checked)

Signature of Manager or Supervisor _____

Printed Name _____