Change/Revoke Request

THIS FORM WILL ALLOW ME, AS A SIMPLICITY HEALTH PLANS MEMBER/PARTICIPANT, TO REQUEST A CHANGE OR REVOCATION TO A PREVIOUSLY APPROVED REQUEST FOR RESTRICTION, CONFIDENTIAL COMMUNICATIONS, PERSONAL REPRESENTATIVE, AUTHORIZATION, OR STATEMENT OF DISAGREEMENT. I UNDERSTAND BY COMPLETING AND SIGNING THIS FORM, I AUTHORIZE SIMPLICITY HEALTH PLANS TO CHANGE OR REVOKE A PREVIOUSLY APPROVED REQUEST. ***

VERIFICATION INFORMATION *(Please Fill in Form or Print Clearly)*

Identification of Member/Participant requesting PHI:
(The following information is needed for verification. Please complete all applicable items)

Name of Member/Participant: _____ Date of Birth: _____/_____/_____

Daytime Phone #: (_____) _____-_____ Evening Phone (_____) _____-_____
(Phone Number is required and necessary if we need to contact you to process your request)

Social Security #: _____-_____-_____

Member/Participant ID card # *(if applicable)*: _____

Group # on ID card: _____

Subscriber Name *(if different from Member/Participant)*: _____

Subscriber's Relationship to Member/Participant: _____

Subscriber's Employer Name: _____

Subscriber's Social Security # *(if different from Member/Participant)*: _____-_____-_____

If you have additional coverage with another employer plan managed by SIMPLICITY HEALTH PLANS, other than described above, please complete the following information:

Other Employer Name: _____

City: _____ State: _____ Zip: _____

Member/Participant ID card #: _____

Group or Account # on ID card: _____

IMPLEMENT RESTRICTION

Please complete this section ONLY if you have an active privacy restriction on file with Simplicity Health Plans.

☐ I wish to revoke my restriction to deny other family Members/Participants covered under my plan access to my Personal Health Information (PHI) via phone and internet.

☐ I wish to revoke all other restrictions. *(Please describe the specific restriction request you wish to revoke)*:

☐ I wish to change the answers to my verification questions: (If you check this box, you must provide the updated answers that you wish to use going forward:

1.) ***What is your mother's date of birth:*** (answer in the following 8-digit format: 09221952 for September 22, 1952; You may use any date, however, it cannot be a future date, and it must be a legitimate calendar date. For example, we cannot accept 09321952, September 32, 1952, because there are not 32 days in September. We also cannot accept 09182025, September 18, 2025, because 2025 is a future date.) ***Date:*** _____

2.) ***What are the last 4 digits of your favorite credit card*** *(you may use any four digit number)*: _____

CONFIDENTIAL COMMUNICATIONS

Please complete this section ONLY if you have an active confidential communications address on file with Simplicity Health Plans.

☐ I wish to revoke my confidential communications address

☐ I wish to change my confidential communications address *(if you check this box, you must provide the updated address you wish to use):*

Street: _____ Apt#: _____
City: _____ State:_____ Zip:_____

PERSONAL REPRESENTATIVE

Please complete this section ONLY if you have an active Personal Representative on file with Simplicity Health Plans.

☐ I wish to revoke my Personal Representative.

☐ I wish to change my Personal Representative information.

(Please check the appropriate box. If you wish to change "My Personal Representative Information," you must first provide the following updated verification answers. For either box above, you must also provide the Personal Representative's updated information)

1.) ***What is your mother's date of birth:*** *(answer in the following 8-digit format: 09221952 for September 22, 1952; You may use any date, however, it cannot be a future date, and it must be a legitimate calendar date. For example, we cannot accept 09321952, September 32, 1952, because there are not 32 days in September. We also cannot accept 09182025, September 18, 2025, because 2025 is a future date.)* ***Date:*** _____

2.) ***What are the last 4 digits of your favorite credit card*** *(you may use any four digit number)*: _____

3.) ***Personal Representative's Information***

First Name:_____***Middle Initial***: _____ ***Last Name***: _____

Street Address: _____ ***Apt #:*** _____

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

Date of Birth *(answer in the following 8-digit format: 09221952 for September 22, 1952)****:*** _____

PRIVACY AUTHORIZATION REQUEST

Please complete this section ONLY if you have an active privacy authorization on file with Simplicity Health Plans.

☐ I wish to revoke my Privacy Authorization

Name of the Individual(s) or Company(ies) that are no longer authorized to receive my PHI:

Specific information that the above-revoked Authorization allowed *(e.g., claims status, medical information, eligibility):*

STATEMENT OF DISAGREEMENT

Please complete this section ONLY if you previously submitted either a Statement of Disagreement or a request to forward information related to a denial of your request to amend PHI.

☐ I wish to revoke my request to have some or all of the following information forwarded when Simplicity Health Plans sends correspondence concerning the disputed information:

my request to amend PHI, the Simplicity Health Plans denial, any Statement of Disagreement, and any Simplicity Health Plans rebuttal

PLEASE NOTE

- If the information on this form is not complete Simplicity Health Plans will return the form to you, and this request will not be considered until Simplicity Health Plans receives complete information.
- If any enrollment information such as Social Security Number (SSN), your Member/Participant ID or date of birth is changed, another form will need to be completed at that time.
- If either the Member/Participant or Group Subscriber changes health care benefits coverage with their employer, another form will need to be completed at that time.

You MUST complete the following signature page.

SIGNATURE AND NOTARIZATION

If your request is regarding a Restriction, Privacy Authorization, or Statement of Disagreement, please complete the signature section labeled A.

If your request is regarding a Personal Representative or Confidential Communications, please complete the signature and notarization section labeled B.

A. SIGNATURE

I have read and understand the above information:

_____Date:_____/_____/_____
Signature of Member/Participant, Parent, Custodian, Guardian or Personal Representative

Relationship if signed by other than Member/Participant: _____
Note: If not already provided, we will require verification of the authority of a Personal Representative before this request will be considered complete.

If this request is made by a Parent, Custodian or Guardian, please complete the following:
I hereby certify that the Member/Participant, _____, is a minor,_____ years of age.

I further certify that I am the parent, custodian and/or guardian *(hereinafter known as "the Legal Representative")* for the above named Minor Member/Participant and that the following information is true and correct:

My Name is:
First Name: _____ Middle Initial: _____ Last Name: _____
My Permanent Residence is located at:
Street Address: _____ *Apt #:*_____
City: _____ *State:*_____ *Zip:*_____
My Social Security Number is: _____-_____-_____

B. SIGNATURE AND NOTARIZATION

To safeguard your privacy and help make sure no one else is requesting access to your information, this request must be notarized. *(Notary services are often provided free of charge at a bank where you have an account.)*

I have read and understand the above information:

_____Date:_____/_____/_____
Signature of Member/Participant, Parent, Custodian, Guardian or Personal Representative

Relationship if signed by other than Member/Participant: _____
Note: If not already provided, we will require verification of the authority of a Personal Representative before this request will be considered complete.

If this request is made by a Parent, Custodian or Guardian, please complete the following:
I hereby certify that the Member/Participant, _____, is a minor,_____ years of age.

I further certify that I am the parent, custodian and/or guardian *(hereinafter known as "the Legal Representative")* for the above named Minor Member/Participant and that the following information is true and correct:

My Name is:
First Name: _____ Middle Initial: _____ Last Name: _____
My Permanent Residence is located at:
Street Address: _____ *Apt #:*_____
City: _____ *State:*_____ *Zip:*_____
My Social Security Number is: _____-_____-_____

State of _____)
) ss.
County of _____)

On this the _____ day of _____, 20 _____, before me,_____ *(Notary Public)*, the undersigned officer, personally appeared _____ *(Member/Participant or Legal Representative's Name)*, known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument and acknowledges that (s)he executed the same for the purposes therein contained.

In witness whereof I hereunto set my hand.

_____
Notary Public

My Commission expires: _____/_____/_____

Please Return This Completed Form To:

Simplicity Health Plans
HIPPA Change
20600 Chagrin Blvd. Suite 450
Cleveland, Ohio 44122