Statement of Disagreement & Request to Forward Denial of Amendment Request

THIS FORM WILL ALLOW ME TO PROVIDE A STATEMENT OF DISAGREEMENT TO SIMPLICITY HEALTH PLANS' * DENIAL OF MY REQUEST TO AMEND MY PRIVATE HEALTH INFORMATION (PHI) THAT SIMPLICITY HEALTH PLANS MAINTAINS.**
I UNDERSTAND IF I DO NOT WISH TO SUBMIT A WRITTEN STATEMENT OF DISAGREEMENT, I MAY STILL REQUEST THAT THE SIMPLICITY HEALTH PLANS' DENIAL OF MY AMENDMENT REQUEST BE FORWARDED.

*****PLEASE NOTE: If you complete this form and your or the Subscriber's employer benefit plan receives reports that contain your disputed PHI, we are required by law to forward to your or the Subscriber's employer your request to amend PHI, the Simplicity Health Plans denial, this form, including any Statement of Disagreement, and any Simplicity Health Plans rebuttal.**

VERIFICATION – *(Please fill in form or Print clearly)*

Identification of Member/Participant:
(The following information is required and needed for verification.)

First Name: ______________________ **Middle Initial:** ________ **Last Name:** ________________________________
Street Address:____
City: ____________________________________ **State:** __________ **Zip:** ______________
Date of Birth: _______/_________/__________ *(MM/DD/YYYY, e.g., 09/29/1952)*

Phone Number where we can reach you if we need to contact you to process your request *(required)*:
Daytime Phone: (______) ________-____________
Evening Phone: (______) ________-____________

Social Security #: _______-_______-__________
Member/Participant ID card number (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 Number *(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 as well:
Other Employer

Name:____

Street Address:____

City: ___________________________________ **State:** __________ **Zip:** ______________

Number on Member/Participant ID card: ____

Group Number on ID card: ____

- **Submission of this form will not lead to the amendment of your information.**
- **If Simplicity Health Plans was not the originator of the information you are requesting to amend, you should contact the originator directly to amend the information. For example, this would apply to your diagnosis, the date of service or the treatment you received. If the provider consents to amend your information and notifies Simplicity Health Plans, we will change the information in our records. In that case, it would not be necessary to submit this form.**

PHI amendment request that was denied and is the subject of your statement of disagreement:

Date of disputed PHI, if applicable:_______/_________/__________ ***(MM/DD/YYYY, e.g., 09/29/1952)***

STATEMENT OF DISAGREEMENT **(Complete if you wish to submit a Statement of Disagreement)**

Describe why you disagree with the denial to amend PHI ***(Please continue on second page if necessary):***

Simplicity Health Plans will forward your request to amend your PHI, the Simplicity Health Plans' denial, this form, including any Statement of Disagreement, and any Simplicity Health Plans' rebuttal when sending correspondence containing the disputed information. We will not forward this information with correspondence to you or the Subscriber.

I DO NOT wish to submit a Statement of Disagreement, but would like your request to amend PHI and the Simplicity Health Plans' denial to be forwarded when Simplicity Health Plans sends correspondence containing the disputed information.

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 has received complete information.
- If 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 changes to a different type of health care benefits coverage provided by Simplicity Health Plans, another form will need to be completed at that time.
- You may change or revoke this request by sending a written request to Simplicity Health Plans, HIPAA Unit, at the address below. You can obtain a *Change/Revoke* form by calling Simplicity Health Plans Member Services at the number on your Simplicity Health Plans ID card.

You must sign page three (3) for this form to be considered complete.

SIGNATURE

I have read and understand the above information:

____Date: _____/______/_______ ***(MM/DD/YYYY, e.g., 09/29/1952)***
(Signature of Member/Participant, Parent/Guardian)

Relationship if signed by other than Member/Participant:____

Note that if not already provided, we will require verification of the authority of a Personal Representative before this request will be considered complete.

If Member/Participant is unable to give consent because of age, complete the following:

I hereby certify that the Member/Participant ______________________________________ is a minor _________ years
(Insert Name of Minor, Member/Participant here)
of age and that I am the parent and/or legal guardian of this minor. *(If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete).*

Please Return This Completed Form To:

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