Request for Access to Health Care Information

THIS FORM WILL ALLOW ME, AS A SIMPLICITY HEALTH PLANS* MEMBER/PARTICIPANT TO REQUEST ACCESS TO PRIVATE HEALTH INFORMATION (PHI) ABOUT ME THAT SIMPLICITY HEALTH PLANS MAINTAINS AND THAT WAS CREATED OR RECEIVED BY SIMPLICITY HEALTH PLANS DURING THE TIME OF MY EMPLOYMENT WITH THE EMPLOYER IDENTIFIED BELOW.

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: _____

REQUEST

Please send the requested information to:

*Street Address:*_____

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

Information Requested from Records Maintained by Simplicity Health Plans:

- ☐ **Adjudicated/Processed Claims** ***(This is a summary of claims paid or denied)***
  (This does not include information on claims received but not yet processed. If you would like the status of those claims, you may call Member Services at the toll free number listed on your or the Subscriber's Simplicity Health Plans ID card.)

- ☐ **Enrollment or eligibility information that Simplicity Health Plans has received from the Subscriber's employer or from the Subscriber/Member/Participant.**
  (This includes information such as name, address, phone number, Social Security Number, etc.)

- ☐ **Case Management and Medical Utilization Management information** ***(CM/MM)***

- ☐ **Other Information** ***(please describe):***

TYPE OF INFORMATION REQUESTED

- ☐ I request the information checked above for my Simplicity Health Plans Medical benefits

- ☐ I request the information checked above for my Simplicity Health Plans Behavioral Health benefits.
  (Please make sure you have coverage through Simplicity Health Plans Behavioral Health before you request this information.)

- ☐ I request the information checked above for my Simplicity Health Plans Dental benefits.
  (Please make sure you have coverage through Simplicity Health Plans Dental before you request this information.)

Most information is maintained and will be provided for a 24 month period. It may not be possible to provide information beyond that period.
There may be other PHI created or maintained by the subscriber's employer/group health plan and/or its business associates and not included in this response for access. You should contact the employer to obtain any additional 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 receives complete information.
- You may not be entitled to receive all of your PHI, and will not receive information such as psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding.

SIGNATURE AND NOTARIZATION

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

I have read and understand the above information. I acknowledge that by signing this form I authorize Simplicity Health Plans to treat my Personal Representative as myself.

_____Date:_____/_____/_____
Signature of Member/Participant/Parent/Guardian

If request is made by a Parent/Guardian for a minor child, 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).*

Notary Public Signature

State of)
) ss.
County of)

On this the _____ day of _____, 20_____, before me, (Notary Public), the undersigned officer, personally appeared_____ (Member/Participant), 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.

_____

My Commission expires: _____/_____/_____

Please Return This Completed Form To:

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