Request for Accounting

BY COMPLETING AND SUBMITTING THIS FORM, I AM REQUESTING AN ACCOUNTING OF MY PRIVATE HEALTH INFORMATION (PHI).

I understand that such accounting will be limited to disclosures that were not for the purposes of treatment, payment or health plan operations and for which I have not provided a written authorization. I realize that most disclosures of PHI are for treatment, payment or health plan operations. The accounting will not include any information disclosed prior to April 14, 2003.

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 (A):_____

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: _____

REQUEST

I am requesting information about disclosures of the following type of information:

☐ Medical care
☐ Dental care
☐ Mental health/behavioral health care

(Please make sure you have coverage through your employer before you request this information)

Please send the information I am requesting to the following address:

Name:_____

Address:_____

City: _____ State: _____ Zip: _____

PLEASE NOTE

- The accounting will not include periods prior to April 14, 2003.
- One accounting per 12-month period is provided free; Simplicity Health Plans may charge for any additional accounting.
- This accounting of your private (protected) information only includes disclosures made by Simplicity Health Plans and its business associates affiliates. It does not include disclosures that may have been made by the subscriber's employer/group health plan, their business associates, or other insurers of the group health plan that may administer your health care benefits. You should contact your employer or those entities to obtain additional information.
- I understand that if the information on this form is not complete Simplicity Health Plans will return the form to me, and this request will not be considered until it has received complete information.
- If any enrollment information such as Social Security Number (SSN), Member 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

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 Accounting
20600 Chagrin Blvd. Suite 450
Cleveland, Ohio 44122