Community HealthFirst™
Medicare Advantage Plans

Information About Your Request to Access Your Protected Health Information (PHI)

What does the right to access PHI mean?

You have the right to look at and get a copy of your information that is kept by Community Health Plan of Washington in the designated record set. The *designated record set* includes records used to make decisions about you as a member. It might also include records about enrollment, claims, plan case management, medical management, or pharmacy information.

What do I need to know to use this right?

You have the right to get or see a copy of your protected health information.

There may be legal limits on your access to your records. For example, a licensed health care professional can limit your access if she or he thinks that giving you the information would endanger your safety or the safety of others.

We will respond to your request within 30 days. If we cannot respond within 30 days, we will send you a written notice that it will take longer.

How much will this cost?

We may charge you a reasonable fee. When a fee applies, we will tell you how much it will be so you can decide if you want to change or cancel your request.

How do I ask for access?

Complete and print the attached form, then mail it to the address at the end of the form.

How will I know if my request is processed?

We will send a letter to the address you write on the form.

In certain cases, Community Health Plan of Washington may deny your request. If we deny your request, we will tell you in writing and let you know if and how you can appeal our decision.

How can I get a full notice of my privacy rights?

A full notice of your privacy rights is on the Community HealthFirst web site at: https://healthfirst.chpw.org/for-members/your-rights-and-privacy/

You may also request a copy by calling the Community Health Plan of Washington's Customer Service department toll free 1-800-942-0247, 7 days a week, from 8am to 8pm. TTY users please call 7-1-1 (toll free).

REQUEST TO ACCESS PROTECTED HEALTH INFORMATION (PHI)

COMMUNITY HEALTH PLAN of Washington™

Section A: Member Information

Member Name: _____ Date of Birth: _____

Member ID #: _____ Date of Request: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Choose One:

☐ OK to leave message with detailed information ☐ Leave message with call back number only

Section B: Delivery of the Requested Information

Request to Access Protected Health Information

I request to review protected health information (PHI) about me in a "designated record set" held by Community Health Plan of Washington in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA).

A *designated record set* includes information that Community Health Plan of Washington uses to make decisions about you. This set might include records about enrollment, claims, plan case management, medical management, or pharmacy information.

Please check only one box below:

☐ I want to review the records identified in Section C during regular business hours at the Community Health Plan of Washington office.

☐ I want the copy to be mailed to me at:

_____ _____ _____ _____

Address *City* *State* *Zip Code*

Please check only one box below:

☐ Yes, Community Health Plan of Washington may give me a summary of my information.

☐ No, Community Health Plan of Washington may NOT give me a summary of my information.

Section C: Details of PHI Request

I request the protected health information (PHI) contained in the following records.

☐ **Enrollment & Eligibility Information**

Date(s) of Enrollment: _____

Details of Request:

_____

☐ **Claims Information**

Date(s) of Service: _____

Provider(s): _____

Details of Request:

_____

☐ **Case or Medical Management Information**

Date(s) of Service: _____

Provider(s): _____

Details of Request:

_____

☐ **Grievance and Appeals Information**

Date(s) of Service: _____

Provider(s): _____

Details of Request:

_____

☐ **Other**

Please Describe:

_____

Section D: Signature and Date

Member or Representative Name: _____

Member or Representative Signature: _____ Date Signed: _____

Please complete the form and return a copy to:

Community Health Plan of Washington
Attention: Compliance, Privacy and Security Officer
1111 Third Avenue, Suite 400
Seattle, WA 98101
Fax: (206) 521-8834
Email: compliance.officer@chpw.org

Please type or print neatly. We will not process incomplete or illegible forms.