Individual Request to Inspect Health Information maintained by Arkansas Blue Cross and Blue Shield

Attn: Customer Service

P.O. Box 2181

Little Rock, AR 72203

I request to review health information held about me in Arkansas Blue Cross and Blue Shield's "Designated Record Set" in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A "Designated Record Set" includes information such as medical records, billing records, enrollment, payment, claims adjudication and health plan case or benefits management record systems used to make decisions about individuals.

The period of service for the records being requested is _____ to _____.

The records being requested were used by Arkansas Blue Cross and Blue Shield to make what decision?

___Denied, amended, discontinued coverage

___General Information

___Denied Claim

___Other (please specify) _____

I understand that Arkansas Blue Cross and Blue Shield has 30 days to respond to this request, and if someone else holds the information or it is off-site, the response time is 60 days. Arkansas Blue Cross and Blue Shield may extend the response time up to an additional 30 days if needed, with written notice to me prior to the original response date.

I request that the information be provided in the following format:

____ Paper

____ Electronic

However, I understand that depending on the record set involved, it may not be possible to receive the information via electronic methods.

I agree to pay any fees for copying my health information. Fees will be reasonable and cost-based, and include only the cost of copying (.25/page) and postage (actual fees). Any fees will be communicated to me prior to the preparation of the request so that I might agree to and arrange payment of the fees.

If I request a prepared explanation of how to read the documents contained in the record set, I understand that a fee will be charged based on the time required to prepare the request and communicated to me prior to the preparation of the request so that I might agree to and arrange for payment of the fees.

I understand that this request does not require release to me of certain health information, including:

(1) information that is not held in the designated record set; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of or for litigation or legal review; and (4) other information not subject to the right to access information under HIPAA.

Name: _____ Daytime Phone Number_____

Address: _____

Member Identification Number _____or Social Security Number _____

Do you participate in the Federal Employees Program _____

Signature_____ Date_____