

Request for Access to Inspect and/or Copy of Protected Health Information



Can you explain what this right means?

You have the right to request a copy of protected health information that Network Health has about you in a designated record set. A record set may include information related to enrollment, billing, claims or medical management.

Network Health is not always required by law to provide access to certain protected health information. For example, Network Health can deny access to psychotherapy notes and information compiled in anticipation of, or for use in, civil, criminal or administrative actions or proceedings.

How do I make a request?

Print and complete the following form. Don't forget to sign and date the form. Return the completed form to:

Network Health
Attn: Compliance Department
1570 Midway Place
Menasha, WI 54952

You will receive a written response indicating the approval or denial of your request.

Request for Access to Inspect and/or Copy of Protected Health Information Form

Complete and mail this form to:

Network Health, Attn: Compliance Department, 1570 Midway Place, Menasha, WI 54952

Complete the following for the individual whose information is being requested:

Name _____ Member/Participant No. _____
Street Address _____ Telephone No. (_____) _____
City/State _____
Zip Code _____ Birth Date _____ / _____ / _____

I _____, hereby request a copy of the protected health information requested below.

Please indicate how you would like to receive the information:

- ☐ Mailed to: _____
☐ Will pick up in person at Network Health
☐ Other (please specify): _____

I request the protected health information contained in the following records. I will specify the details for you in the blanks below.

☐ Enrollment Information (underwriting and application process)

Specify Information Requested _____
Detail of Issue _____

☐ Claims Information

☐ Claim ☐ Service provided
Date(s) of Service _____
Provider(s) _____
Detail of Issue _____

☐ Case or Medical Management Information

Date(s) of Service _____
Provider(s) _____
Specify Information Requested _____
Detail of Issue _____

☐ Billing/Premium Information

Billing Period _____
Detail of Issue _____

☐ Other

Please describe _____

Pursuant to federal law, I understand that Network Health may deny this request. By signing this form, I am confirming that it accurately reflects my wishes.

Signature of Requestor _____ Date _____

☐ Check here if you are the member's legal representative (If other than parent or legal guardian, you must attach a copy of authorization)

Relationship _____ Authority _____
Name _____ Phone number _____

(If you are the personal representative, other than a parent or legal guardian, please attach a copy of any documents verifying your position as personal representative.)

(Please submit a separate request for each individual.)