THE OHIO STATE UNIVERSITY
HEALTH PLAN

Access Request Form

You have the right of access to copy or inspect certain portions of your personal health information held by The Ohio State University Health Plan Inc. We are not always required to grant such access but each request will be carefully reviewed and approved if warranted. You will be notified when your request has been approved or denied and the reasons for any denial. Access denial reasons can be found on the back of this form.

Section I: Member/Dependent Information -All fields are mandatory and should be completed in order for the form to be processed timely. Please Print Clearly & Legibly

Name_____ Date of Birth_____/_____/_____

Address_____ City_____

State and Zip _____ Phone_____

E-mail Address_____

Section II: OSU Employee/Subscriber Information

Name_____

Trustmark Member ID Number_____

Section III: Information Released to-If not to the Requestor:

Name _____

Address_____ City _____

State and Zip_____ Phone_____

Section IV: Protected Health Information (PHI) you wish to review:

Organization

- ☐ The OSU Health Plan
- ☐ Trustmark
- ☐ Zelis Healthcare

Information to Review

- ☐ Claims
- ☐ Appeals
- ☐ Payment information
- ☐ Other_____

Dates of Service Requested: _____

You have the option to receive the requested information in summary form with an explanation of what the information says in lieu of or in addition to the requested information.

- ☐ Yes, send me a summary/explanation *instead* of the complete information.
- ☐ Yes, send me a summary/explanation *in addition to* the complete information.
- ☐ No, send me the complete information only.

This form must be accompanied by signature page on the second page of this form.

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I wish to:

- ☐ Receive a copy of the information requested by mail.
- ☐ Come in and pick up a copy of the information.
- ☐ Have the information sent to me via email (summary only).
- ☐ Other: _____

_____ _____
Member Signature (Digital/electronic signature is not accepted) **Date**

_____
Print Name

If you are a personal representative of a member, please provide documentation or explanation of your authority to act for the member.

Please note that we will not process any requests that are not signed by you or your personal representative. We will not process any forms that are signed by electronic/digital signature.

For this Access Request form to be valid, it must be filled out accurately and completely.

Return this form to the HIPAA Privacy Officer, OSU Health Plan, Inc., 700 Ackerman Road, Suite 1007, Columbus, Ohio 43202 or fax to (614) 292-8366.

Denial of Access

We are permitted by law to deny part or all of your request for access for one or more of the following reasons:

- Your access request form is not signed by you or your representative;
- Your access request form is not signed by your representative and the representative has not provided information on the source of his/her authority to act for you;
- We do not maintain the information you have requested to copy or inspect;
- The information you have requested is not part of our records;
- Your request is for psychotherapy notes;
- Your request includes information complied for litigation;
- Your request includes information created or obtained in the course of research still in progress that includes your treatment and you agreed to this denial of access when consenting to participate in the research;
- A licensed health professional has determined that the requested access is likely to either endanger your or another person's life or safety or cause substantial harm to you or another person;
- Your request is to copy information and you are an inmate in a correctional facility (you retain the right to inspect the information);
- Your request relates to certain information that was obtained from a confidential source and we are not required to provide access to it by law.

FOR OSU HEALTH PLAN PRIVACY OFFICE USE:

APPROVED BY:_____ **DATE:**_____
OSU Health Plan HIPAA Privacy Officer

REASON DENIED: _____

DENIED BY:_____ **DATE:**_____
OSU Health Plan HIPAA Privacy Officer

DOCUMENT(S) SENT (NAME OR ORGANIZATION) BY: _____

DATE DOCUMENT(S) SENT TO MEMBER: _____