



Accounting Request Form

You have the right to receive an accounting of any disclosures made by The Ohio State University Health Plan Inc. of your health and medical information. The following information is required to process your request:

Section I: Member Information (Please Print Clearly & Legibly)

Name _____

Date of Birth ____/____/____

Address _____ City, State, Zip _____

Phone _____ E-Mail Address _____

Section II: OSU Employee/Subscriber Information

Name _____

Trustmark Member ID _____

Section III: Requestor Information (complete if you are not the member)

Name _____

Address _____

Relationship to Member _____ Phone _____

Organizations from which you wish to receive an accounting:

OSU Health Plan Trustmark-Medical Claims OSU Health Plan (UFSAP/EAP) Zelis Healthcare

Other (Must be specify) _____

Period of time for which you wish to see the disclosures made _____

We are not required by law to include any of the following disclosures of your health information in an accounting to you:

- Disclosures made pursuant to an authorization signed by you or your representative;
- Disclosures to carry out our own or other providers' or plans' treatment, payment and health care operations;
- Disclosures made to you or to your personal representative;
- Disclosures made to persons involved in your care and/or payment or notification of next-of kin or family members;

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

- Disclosures for national security or intelligence purposes;
- Disclosures to correctional institutions or law enforcement officials about inmates or others in custody; or
- Disclosures that occurred prior to April 14, 2003

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 with digital/electronic signature.

Signature (Digital/electronic signature is not accepted)

Date

Print Name

For this Accounting 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.

FOR OFFICE USE:

APPROVED BY: _____
OSU Health Plan HIPAA Privacy Officer

Date: _____

REASON DENIED: _____

DENIED BY: _____
OSU Health Plan HIPAA Privacy Officer

DATE: _____