THE OHIO STATE UNIVERSITY
HEALTH PLAN

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.

All fields on this form are mandatory and should be completed for the form to be processed timely. One member/dependent request per form. **Please Print Clearly & Legibly**

Section I: Member Information

Name_____

Date of Birth_____/_____/_____

Address_____ City, State, Zip_____

Phone_____ E-Mail Address_____

Section II: OSU Employee/Member Information:

Name_____

Trustmark Member ID_____

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

Name _____

Address_____

Relationship to Member_____ Phone_____

Section IV: Organizations from which you wish to receive an accounting:

☐ OSU Health Plan ☐Trustmark-Medical Claims ☐OSU Health Plan (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;

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

- 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;
- 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.

If Personal Representative, source/document, such as Healthcare Power of Attorney, of authority to act for Member is required.

_____ _____
Member Signature or Personal Representative Signature **Date**

_____
Print Name

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

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

FOR OFFICE USE:

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

REASON DENIED:_____

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