THE OHIO STATE UNIVERSITY
HEALTH PLAN

Access Request Form

You have the right of access to copy and/or inspect certain portions of your protected health information held by The Ohio State University Health Plan Inc. ("OSUHP") Each request will be carefully reviewed. 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. One member/dependent request per form. Please Print Clearly & Legibly

Name_____ Date of Birth_____/_____/_____

Address_____ City_____

State and Zip _____ Phone_____

E-mail Address_____

Luminare Member ID Number_____

Section II: Information Directed to (If not to the Member/Dependent): Member/Dependent hereby directs OSUHP to transmit a copy of the PHI identified below to the following:

Name _____

Address_____ City _____

State and Zip_____ Phone_____

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

Organization

☐ The OSU Health Plan
☐Luminare
☐Other_____
_

Information to Review

☐ Claims
☐ Appeals
☐ Payment information
☐ Other_____

Date(s) of Service Requested (**NOTE: Please provide specific date(s) &/or specific date range**):

_____

I wish to:

☐ Inspect a copy of the information at a mutually agreed upon time and place.
☐ 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 encrypted email at the following e-mail address_____. By providing my e-mail address here, I hereby consent to receive e-mail communications from OSUHP.

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

You have the option to receive the requested information in summary form from Luminare with an explanation of what the information says in lieu of the requested information. Luminare may impose a fee for such summary which must be agreed upon by you in advance.

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

_____ _____

Member Signature or Personal Representative Signature **Date**

_____

Print Name

If you are a personal representative of a member, source/document, such as Healthcare Power of Attorney, of authority to act for Member is required.

Please note that we will not process any requests that are not signed by you or your personal representative.

For this Access 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 or email OSUHealthPlanCS@osumc.edu.

FOR OSU HEALTH PLAN PRIVACY OFFICE USE:

APPROVED BY:_____ **DATE:**_____

OSU Health Plan HIPAA Privacy Officer

DENIED BY:_____ **DATE:**_____

REASON DENIED: _____

1. DOCUMENT(S) SENT (NAME OF ORGANIZATION) FROM: _____

DATE DOCUMENT(S) SENT TO MEMBER: _____

2. DOCUMENT(S) SENT (NAME OF ORGANIZATION) FROM: _____

DATE DOCUMENT(S) SENT TO MEMBER: _____

3. DOCUMENT(S) SENT (NAME OF ORGANIZATION) FROM: _____

DATE DOCUMENT(S) SENT TO MEMBER: _____