

MEMBER REQUEST FOR HEALTH PLAN RECORDS



MEMBER'S HEALTH PLAN:

- | | | |
|--|--|--|
| <input type="checkbox"/> COHO Benefits of CTSI | <input type="checkbox"/> Samaritan Choice Plans | <input type="checkbox"/> IHN |
| <input type="checkbox"/> Samaritan Advantage Health Plan | <input type="checkbox"/> Samaritan Healthy KidsConnect | <input type="checkbox"/> Samaritan Portability Benefit Plans |

MEMBER INFORMATION:

Last Name:	First Name:	MI:
Phone #:	Date of Birth: ____ / ____ / ____	Health Plan ID #:

Address:

REQUEST:

I request copies of the following health plan records. By placing my initials next to any of the items below, I am specifically requesting the release of the selected item(s), if such record exists (initial all items that apply):

- ____ Call history ____ Claims data ____ Prior authorization and/or chart notes
____ Eligibility data ____ Appeal and/or grievance documentations
____ Other (please describe): _____

List date(s) of service or describe what this request is connected to:

SIGNATURE:

I understand that this is a onetime request for my health plan records. I will receive the records no later than 30 days from the date requested. I understand that I have the right to access my health plan records. Signing this form will not affect my health care treatment, payment, enrollment in my health plan, or eligibility for benefits.

SIGNATURE: _____ Date: _____

If you are the Authorized Representative, you must sign above and provide the following information:

Name: _____ Phone: _____

Address: _____ Relationship to Enrollee: _____

FAX completed form to (541) 768-6701
MAIL to Samaritan Health Plan Operations, Attn: Customer Service, PO Box 1310, Corvallis, OR 97339

SHPO USE ONLY: Completed date: _____ Staff initials: _____