

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:
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Phone #:	Date of Birth: ____ / ____ / ____	Health Plan ID #:
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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: _____
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