Request for Access to Inspect and/or Copy Protected Health Information

ASSURANT Health

Complete and mail this form to:

Assurant Health, PO Box 354, Milwaukee, WI 53201-0354

Complete the following for the individual whose information is being requested:

Name ______________________ Policy No. ______________________

Street Address ______________________ Telephone No. (______) ______________________

City/State ______________________ Birth Date __________ /__________/__________

ZIP Code ______________________

I ______________________, hereby request a copy of the protected health information requested below. **Please mail to me at:**

☐ the address above ☐ an alternate address: ______________________

I request the protected health information contained in the following records. I will specify the details for you in the blanks below.

☐ **Enrollment Information (underwriting and application process)**

Provider(s) ______________________

Detail of Issue ______________________

☐ **Claims Information**

This is regarding ☐ a claim ☐ a service provided

Date(s) of Service______________________

Provider(s)______________________

Detail of Issue______________________

☐ **Case or Medical Management Information (pre-authorization)**

Date(s) of Service ______________________

Provider(s) ______________________

Detail of Issue ______________________

☐ **Billing/Premium Information**

Billing Period______________________

Detail of Issue______________________

☐ **Other**

Please describe: ______________________

____

☐ Check here if you would like to inspect and/or copy the requested information in person at Assurant Health in Milwaukee, Wisconsin, at your own expense. We will contact you to arrange for a mutually convenient time.

Pursuant to Federal law, I understand that Assurant Health may deny this request. By signing this form, I am confirming that it accurately reflects my wishes.

Signature of Requestor ______________________ Date ______________

If signed by a Personal Representative:

Name of Personal Representative ______________________ Telephone No. (______) ______________

Relationship to individual or nature of authority ______________________

Signature of Personal Representative ______________________ Date ______________

(If you are the Personal Representative, other than a parent or legal guardian, please attach a copy of any documents verifying your position as Personal Representative.)

(Please submit a separate request for each individual)

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Can you explain what this right means?

You have the right to request a copy of protected health information that Assurant Health has about you in a designated record set. A record set may include information related to enrollment, billing, claims or medical management.

Assurant Health is not always required by law to provide access to certain protected health information. For example, Assurant Health can deny access to psychotherapy notes and information compiled in anticipation of, or for use in, civil, criminal or administrative actions or proceedings.

How much will this cost me?

There is no cost to you.

How do I make a request?

Print and complete the form below. Don't forget to sign and date the form. Mail the completed form, with any appropriate fees, to: Assurant Health, PO Box 354, Milwaukee, WI 53201-0354.

Please do not include these instructions with your request.

A written response, indicating the approval or denial of your request, will be sent to the address you provide on the form.