
Request for Access to Protected Health Information

You have a right to access and inspect the personal information that United Behavioral Health (UBH), or its affiliate U.S. Behavioral Health Plan of California (USBHPC), maintains and uses to make decisions about your behavioral health benefits. HIPAA calls this your Protected Health Information (PHI) that is maintained in a Designated Record Set (DRS). This Designated Record Set includes enrollment information, claim requests for payment, claim payment, case or medical management records, appeals and/or complaints files, and other records that are used in whole or in part to make decisions about your benefits.

You can request information only about yourself, unless you are legally authorized to get information about another individual.

In an effort to make this information more understandable to you, we can provide you with a report that summarizes your eligibility, claims, and treatment authorization information as far back as six years from the date of your request. Please be aware that if you ask for this summary and if no claims have been processed for your behavioral health treatment in the past six years, we may only be able to supply you with your eligibility records. If you request this eligibility, claims, and treatment authorization summary now, and later decide that you want supplemental information, you can request additional information at that time. If you need more detailed information now, you may request it.

When completing this form, please:

- Complete all sections entirely;
- Print information clearly;
- Provide us with your most current information.

Indicate the type of records you are requesting on the attached form, and the dates for which you want that information. Again, please be aware that the furthest back we can provide you with information is six years.

We will respond to requests from a personal representative authorized by a Member to receive his or her Protected Health Information (e.g., parent, court appointed representative, family member). However, we may require additional documentation from the Member or the Member's personal representative to verify his or her authority to act on the Member's behalf.

Please note that we will only supply you with Protected Health Information regarding behavioral health benefits administered by United Behavioral Health or its affiliates. To obtain your PHI concerning your medical, dental or any other covered entity benefit not managed by UBH or its affiliates, you must contact the entity that administers those benefits directly. If we are unable to send you a copy of your PHI within 30 days from the date we receive your request, you will be contacted and advised about the delay.

If you have any questions about filling out this form, please contact 1-866-604-3273 and dial "0" to speak with a Customer Service Representative.

Request for Access to Protected Health Information

Use this form to request access to your Protected Health Information from United Behavioral Health. Complete this form in its entirety (front and back) to ensure your Protected Health Information can be located and released. Once the request is approved, a copy of your Protected Health Information will be mailed to you or your authorized personal representative.

Section 1: Protected Health Information Requested For:

Name _____ Address _____

City _____ State _____ Zip _____ Phone (_____) _____

Date of Birth _____ Male _____ Female _____

Relationship to Subscriber: Self _____ Spouse _____ Child _____ If other, describe type of relationship _____

Section 2: Type(s) of Information Requested

Please choose one of the three options below to indicate what type(s) of information you would like to receive:

- (Option 1) I would like a report that summarizes my eligibility, claims, and treatment authorization information.
- (Option 2) I would like the following information (if applicable):
- Eligibility
 - Claims payment/adjudication information
 - Treatment authorizations (for mental health, substance abuse, and EAP)
 - Care management of my mental health/substance abuse benefit
 - EAP case details
 - Appeals/complaints I have filed
- (Option 3) I have previously requested a summary report of my eligibility, claims, and treatment authorization information and would like more detailed information about the following claims or treatment authorizations:

Claim Number(s) _____

Authorization Number(s) _____

Information Requested (relating to these specific claims/authorizations):

- Detailed claims payment/adjudication information
- Care management of my mental health/substance abuse benefit
- EAP case details
- Appeals/complaints I have filed

Section 3: Date Range of Information Requested

I would like this information for the following dates:

- From six years prior to the date of this request
- From _____ (MM/DD/YY) to _____ (MM/DD/YY)

(Please remember we cannot provide information older than six years from the date of your request)

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Section 3 (continued)

An authorized signature of the individual, or authorized signature of the personal representative of the individual, who is requesting the Protected Health Information is required:

I authorize the release of my Protected Health Information to me at the address stated in Section 1 of this form. I understand that this request does not apply to certain health information, including: (1) information that is not received or maintained by United Behavioral Health; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of or for litigation; and (4) other information not available for access under HIPAA.

Signature of Individual: X _____ Date _____

Signature of Personal Representative if applicable: X _____ Date _____

Personal Representative's Name _____

Address _____

City _____ State _____ Zip _____ Phone (____) - _____

Relationship to individual and authority to act for individual _____

Important: A personal representative, including a parent, legal guardian, or executor of an estate, may be required to supply a copy of legal documentation. If you have questions, please call 1-866-604-3273 and select "0" to speak with a Customer Service Representative who can answer your questions about legal documentation.

Section 4: Subscriber Information

Subscriber Identification Number _____ Group Number _____ Employer _____

Subscriber Name _____ Address _____

City _____ State _____ Zip _____ Phone (____) - _____

Please return the completed form to:

United Behavioral Health
Privacy Lead
Compliance Department
P.O. Box 99378
Emeryville, CA 94662-9378