



Access Request Form

You have the right of access to copy or inspect certain portions of your personal health information held by The Ohio State University Health Plan Inc. We are not always required to grant such access but each request will be carefully reviewed and approved if warranted. 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 \_\_\_\_\_

Section II: OSU Employee/Subscriber Information

Name \_\_\_\_\_

Trustmark Member ID Number \_\_\_\_\_

Section III: Information Released to-If not to the Requestor:

Name \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

State and Zip \_\_\_\_\_ Phone \_\_\_\_\_

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

Organization

Information to Review

- The OSU Health Plan
 Trustmark
 Zelis Healthcare

- Claims
 Appeals
 Payment information
 Other \_\_\_\_\_

Date(s) of Service Requested (NOTE: Must be specific date(s) &/or specific date range):

\_\_\_\_\_

You have the option to receive the requested information in summary form with an explanation of what the information says in lieu of or in addition to the requested information.

- Yes, send me a summary/explanation instead of the complete information.
 Yes, send me a summary/explanation in addition to the complete information.
 No, send me the complete information only.

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



I wish to:

- 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 email (summary only). Email Address: \_\_\_\_\_
- Other: \_\_\_\_\_

\_\_\_\_\_  
Member Signature (Digital/electronic signature is not accepted)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

If you are a personal representative of a member, please provide documentation or explanation of your authority to act for the member.

**Please note that we will not process any requests that are not signed by you or your personal representative. We will not process any forms that are signed by electronic/digital signature.**

**For this Access Request form to be valid, it must be filled out accurately and completely.**

**Return this form to the HIPAA Privacy Officer, OSU Health Plan, Inc., 700 Ackerman Road, Suite 1007, Columbus, Ohio 43202 or fax to (614) 292-8366.**

**Denial of Access**

We are permitted by law to deny part or all of your request for access for one or more of the following reasons:

- Your access request form is not signed by you or your representative;
- Your access request form is not signed by your representative and the representative has not provided information on the source of his/her authority to act for you;
- We do not maintain the information you have requested to copy or inspect;
- The information you have requested is not part of our records;
- Your request is for psychotherapy notes;
- Your request includes information compiled for litigation;
- Your request includes information created or obtained in the course of research still in progress that includes your treatment and you agreed to this denial of access when consenting to participate in the research;
- A licensed health professional has determined that the requested access is likely to either endanger your or another person's life or safety or cause substantial harm to you or another person;
- Your request is to copy information and you are an inmate in a correctional facility (you retain the right to inspect the information);
- Your request relates to certain information that was obtained from a confidential source and we are not required to provide access to it by law.

**FOR OSU HEALTH PLAN PRIVACY OFFICE USE:**

APPROVED BY: \_\_\_\_\_  
OSU Health Plan HIPAA Privacy Officer

DATE: \_\_\_\_\_

REASON DENIED: \_\_\_\_\_

DENIED BY: \_\_\_\_\_  
OSU Health Plan HIPAA Privacy Officer

DATE: \_\_\_\_\_

DOCUMENT(S) SENT (NAME OR ORGANIZATION) BY: \_\_\_\_\_

DATE DOCUMENT(S) SENT TO MEMBER: \_\_\_\_\_