Wellmark Advantage Health Plan

Wellmark Advantage Health Plan, Inc. is an independent licensee of the Blue Cross and Blue Shield Association.

Request for Access to Designated Protected Health Information Records

Use this form to request to inspect or obtain copies of your protected health information in the designated record set that we or our business associates, maintain.

Please provide the following information:

Name			Daytime phone number
Address			
City	State	ZIP code	Enrollee ID

You have the right to inspect or obtain a copy of protected health information in your designated record (except certain limited information, including: copies of psychotherapy notes, information we have compiled in anticipation of, or for use in a, civil, criminal or administrative action or proceeding, and certain other records). Elements in the designated record may include: eligibility, enrollment, payment, claims, appeals and case or medical management records. Unless you indicate otherwise, we will provide a summary of the records.

1. I am requesting:

   ☐ A summary of all records maintained in the designated record set:

   From: _____ _____
   Month Year

   To: _____ _____
   Month Year

   ☐ Specific records:

2. Does this request include information about services received at a Blue Care Network Health Center? ☐ Yes ☐ No

3. The manner in which you prefer to access your records:

   ☐ Paper copies mailed to: _____
   Name of recipient

   _____
   Street address

   _____
   City, state, ZIP code

   ☐ In person. I would like to review the records in person at a location designated by Wellmark Advantage Health Plan.

(Please complete the form on the opposite side)

Y0156_IGWlmrkRqAcsDsgnPHI_C FVNR 0821

☐ Electronically. Please select the format to receive your copies:

☐ PDF

☐ Other (please specify): _____

I would like my electronic copies delivered to:

☐ An email address: _____
Name of recipient

_____
Email address of recipient

☐ A postal address: _____
Name of recipient

_____
Street address

_____
City, state and ZIP code

Please send the copies on a: ☐ CD-ROM

☐ USB storage device

☐ Other (please specify) _____

4. Please sign and date:

_____ _____
Signature *Date*

If you are not the member, please sign and write today's date below, then check the box that describes your relationship to the member. If you are not the parent of a minor member, please attach proof of your relationship to the member. An authorization is required if you are not the personal representative.

Name of personal representative: _____

Signature of personal representative and date: _____

☐ Parent of minor child ☐ Legal guardian ☐ Power of attorney ☐ Executor ☐ Other

Please include the fax number as shown below.
Please mail completed form (and all documentation if needed) to: **Customer Individual Rights Unit**
600 East Lafayette, MC 1620
Detroit, MI 48226-2998

or Fax to: **1-877-522-4767.**

Wellmark Advantage Health Plan will make reasonable attempts to produce the designated record in the form and format you have requested. However, in the event that we cannot produce the records in the form and format you have requested, we have the right to contact you to establish a mutually agreeable alternative. We reserve the right to charge a reasonable fee to produce the copies in the form and format you have requested.