MASSACHUSETTS

Request for Access to or Copies of Protected Health Information in Designated Record Set

Use this form to request to inspect or obtain copies of your protected health information in the designated record set (Records) that Blue Cross and Blue Shield of Massachusetts (Blue Cross) maintains. These Records may include, for example, medical and billing records, enrollment, payment, claims adjudication and appeals, and case management information.

Please retain a copy of this form for your records and mail or fax completed form to:
Blue Cross Blue Shield of Massachusetts, Inc.
101 Huntington Avenue – Suite 1300
Boston, MA 02199-7611
Attention: Law Department – Mailstop 01/18
Privacy Program Manager
Fax: (617) 246-3550

A. MEMBER INFORMATION

Member's name: _____ Date of birth: _____

Member's ID#: _____ Date of request: _____

Address: _____

Phone number: _____

B. I AM REQUESTING:

☐ To view Records in person at a location designated by Blue Cross

☐ To obtain copies of the following Records *(if you are requesting EOBs/claims, Blue Cross may provide this information in a chart letter that supplies all applicable information in summary form, rather than actual copies of EOBs/claims)*

Describe the information you are requesting to view or obtain copies of:

☐ a copy of all Records for time period identified below

OR

☐ only the following Records for time period identified below

(please describe)_____

_____

_____

Date(s) associated with request *(be as specific as possible):*

C. PLEASE INDICATE THE MANNER IN WHICH YOU PREFER TO RECEIVE COPIES OF YOUR RECORDS

☐ Paper copies mailed to the current address Blue Cross has for me in its records.

☐ Paper copies mailed to the address listed in section D, below.

☐ Paper copies mailed to another person at the address listed in section D, below. (You must complete an Authorization for Release of Information to this other person before Blue Cross can honor this request).

☐ Electronic records:

☐ PDF file emailed to: _____
Email address

_____
Name of recipient

☐ CD-ROM ☐ USB Storage ☐ Other (describe) _____

Send CD-ROM, USB or other to: ☐ The current address Blue Cross has for me in its records.

☐ The address listed in section D, below.

☐ Another person at the address listed in section D, below. (You must complete an Authorization for Release of Information to this other person before Blue Cross can honor this request).

I understand that Blue Cross may charge a reasonable fee to produce copies in the form and format I have requested. I understand that Blue Cross will notify me of its decision to approve or deny my request to access or obtain a copy of the Request Information within thirty (30) days of receiving this request. If Blue Cross is unable to comply with my approved request within the applicable time limit, it may extend the applicable deadline for up to thirty (30) days by notifying me in writing. If the information on this form is not complete, Blue Cross will return the form to you, and this request will not be considered until Blue Cross has received complete information.

D. ALTERNATE ADDRESS (complete if you would like the Records sent to an address that differs from the one Blue Cross has for you in its records)

Please send my records to this address, rather than the current address Blue Cross has for me in its records:

_____
Name of Recipient

_____
Street Address

_____
City, State, ZIP code

E. SIGN AND DATE

Signature of member/legal representative: _____Date:_____

Name legal representative (if applicable): _____Relationship:_____

Questions regarding this form should be directed the Privacy Program Manager at (617) 246-3500

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711).

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID
(TTY: 711).