Meridian Health Plan

Request for Protected Health Information

This form is to be used by a member to request to inspect and/or obtain copies of his or her own Protected Health Information (PHI) or records as long as the PHI is maintained by Meridian Health Plan (MHP) in a designated record set. A designated record set is made up of enrollment, payment, claims and case or medical management records maintained by MHP and used to make decisions about the member. Please read the following before completing the request:

You have the right to inspect or obtain a copy of your protected health information in designated record sets we maintain. You are not entitled to inspect or obtain a copy of any psychotherapy notes we may have, any information we may have compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding, any information not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988, and certain other records as designated in the Privacy Rule. You will receive a written response to your request within 30 days of our receipt of this form.

Please help us meet your request by providing the following information:

Member Name: _____ Medicaid ID #: _____

Address: _____ Date of Birth: _____
(MM/DD/YYYY)

City/State/Zip: _____ Phone #: _____-_____-_____

Additional information about your request:

1. Please describe the specific records you are requesting: _____
   _____
2. Please specify the date range for the records you are requesting:
   FROM (MM/DD/YYYY): _____ TO (MM/DD/YYYY): _____
3. The reason you are requesting the records:
   - ☐ For a lawsuit, legal action, court case, settlement, etc.
   - ☐ To help coordinate my health care.
   - ☐ For my own personal records.
   - ☐ Other: _____
4. Please tell us how you would like to inspect or obtain a copy of your records.
   - ☐ In person at a location decided by Meridian Health Plan (an appointment is required).
   - ☐ By mail at the address listed above.

   **** Please note that there may be a 10 cent per page charge for copying records and postage fees for mailing.***

Member Signature: _____ Date (MM/DD/YYYY): _____

If a personal representative signs this authorization on behalf of the member, they must specify their relationship to the member and provide documentation of your authority to obtain PHI on behalf of the member.

Personal Representative Name: _____ Signature: _____

Relationship to the individual (Attorney, Guardian, etc.): _____

Return this form to: Chief Privacy Officer
Meridian Health Plan
222 North LaSalle Street, Suite 930
Chicago, IL 60601

If you need assistance in completing this form please call Member Services at 1-866-606-3700.