AmeriHealth
ADMINISTRATORS

Request for an Accounting of Disclosures of Protected Health Information

Date Of Request: _____

Participant Name: _____

Participant Address: _____

Agreement Number: _____ Date of Birth: _____

Address To Send Disclosure Accounting (If Different From Above):

_____

I would like an accounting of all disclosures for the following time frame:
Please note: the maximum time frame that can be requested is six years prior to the date of request, but not before April 14, 2003.

From: _____ To: _____

Fees: First request in a 12-month period is free. Subsequent Requests: $ _____

The fee for this request will be: $ _____

I understand that there is a fee for this accounting and wish to proceed. I also understand that the accounting will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed.

_____ _____
Signature of Participant or Legal Representative Date

For AmeriHealth Administrators Use Only:

Date Received: _____ Date Sent: _____

Extension Requested: ☐ No ☐ Yes, Reason _____

Participant notified in writing on this date: _____

Identity of participant and/or legal representative obtained/filed ☐ Yes ☐ No

Associate processing request: _____