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: _____

To: _____
_____
_____

Enclosed is the form you have requested. Please complete and return all pages of the form to our attention:

AmeriHealth Administrators
Attn: Privacy Official
1900 Market Street, Suite 500
Philadelphia, PA 19103

- Only fully completed forms will be accepted.
- Forms must be typed or legibly written.
- Forms must be signed and dated.

We will begin to process your request on the day it is received. If your request is denied for any reason, you will receive an explanation of the denial.