Individual request to inspect health information maintained by BlueAdvantage Administrators of Arkansas

I request to review health information held about me in BlueAdvantage Administrators of Arkansas' "Designated Record Set" in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that BlueAdvantage Administrators of Arkansas is a third-party claims administrator providing services for my Employer's Group Health Plan. A "Designated Record Set" includes information such as medical records, billing records, enrollment, payment, claims adjudication and health plan case or medical management record systems used to make decisions about individuals.

The period of service for the records being requested is _____ (date in mm/dd/yyyy format) to _____ (date in mm/dd/yyyy format).

The records being requested were used by BlueAdvantage Administrators of Arkansas to make what decision?

☐ Denied, amended, discontinued coverage

☐ General information

☐ Denied claim

☐ Other (please specify) _____

I understand that BlueAdvantage Administrators of Arkansas has 30 days to respond to this request, and if someone else holds the information or it is off-site, the response time is 60 days. BlueAdvantage Administrators of Arkansas may extend the response time up to an additional 30 days if needed, with written notice to me prior to the original response date.

I request that the information be provided in the following format: ☐ Paper ☐ Electronic

However, I understand that depending on the record set involved, it may not be possible to receive the information via electronic methods.

I understand that I can inspect the requested information at BlueAdvantage's offices located at 320 West Capitol, Suite 247, Little Rock, Arkansas 72201. If I so request and the information can be provided via paper or diskette, it will be mailed to the address I specify on this request.

I agree to pay any fees for copying my health information. Fees will be reasonable and cost-based, and include only the cost of copying (.25/page) and postage (actual fees). Any fees will be communicated to me prior to the preparation of the request so that I might agree to and arrange payment of the fees.

If I request a prepared explanation of how to read the documents contained in the record set, I understand that a fee will be charged based on the time required to prepare the request and communicated to me prior to the preparation of the request so that I might agree to and arrange for payment of the fees.

I understand that this request does not apply to certain health information, including (1) information that is not held in the designated record set; (2) psychotherapy notes; (3) information compiled in reasonable anticipation of or for litigation or legal review; and (4) other information not subject to the right to access information under HIPAA.

First name	**Middle initial**	**Last name**	**Phone**

Address	**City**	**State**	**ZIP**

Member ID	**Social Security number**

Signature	**Date signed** (mm/dd/yyyy)

Send completed form to your employer's Human Resources or Benefits Administration Office.