



## Community Health Plan of Washington Request Access to Protected Health Information (PHI)

Use this form to request a copy of your protected health information (PHI) that is kept by Community Health Plan of Washington (CHPW) in the designated record set. The designated record set includes records used to make decisions about you as a member. It might also include records about enrollment, claims, plan case management, medical management, or pharmacy information.

There may be legal limits on your access to records. For example, a licensed health care professional can limit your access if they think that giving you the information would endanger your safety or the safety of others. We may charge you a reasonable fee. When a fee applies, we will tell you how much it will be so you can decide if you want to change or cancel your request.

1. **Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Member ID Number:** \_\_\_\_\_ **Date of Request:** \_\_\_\_\_

**Member Address:** \_\_\_\_\_

**Member email:** \_\_\_\_\_

**Member Phone:** \_\_\_\_\_ **Member Fax:** \_\_\_\_\_

**Choose one:**  Ok to leave message with detailed information.  
 Leave message with call-back number only.

2. I request to review my PHI in a “designated record set” held by CHPW in accordance with the Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA).

**2A: check only one box to tell CHPW how you want to review your requested records outlined below:**

- I want to review my PHI during regular business hours at the CHPW office.
- I want a copy of my PHI to be emailed/mailed to me at:

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**2B: check only one box below to tell CHPW whether you want a summary of your PHI:**

Yes, CHPW may give me a summary of my PHI.

No, CHPW may **not** give me a summary of my PHI.

**3. I request the PHI contained in the following records.**

**Enrollment and Eligibility Information:**

Date(s) of enrollment: \_\_\_\_\_

Details of request: \_\_\_\_\_

**Claims information:**

Date(s) of service: \_\_\_\_\_

Provider(s): \_\_\_\_\_

Details of request: \_\_\_\_\_

**Case or Medical Management Information:**

Date(s) of service: \_\_\_\_\_

Provider(s): \_\_\_\_\_

Details of request: \_\_\_\_\_

**Grievance and Appeals Information:**

Date(s) of service: \_\_\_\_\_

Provider(s): \_\_\_\_\_

Details of request: \_\_\_\_\_

**Other (please describe):**

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4. I understand that a copy of my PHI will be provided to me within 30 days of the date of this request, unless CHPW extends the timeframe for an additional 30 days and provides me with a written statement for the reason(s) for the delay and the date by which I can expect to receive a copy of the information. I understand that in certain cases CHPW may deny my request and will notify me in writing if my request is denied and will inform me how I can appeal the denial decision. I understand that communication via mail or email may not be secure.

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**Printed Name**

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**Phone**

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**Date**

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**Signature**

Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (e.g., Power of Attorney). This only applies if someone other than the member signed above.

**Telephone Number of Personal Representative:** \_\_\_\_\_

**Personal Representative's relationship to the member:** \_\_\_\_\_

**5. Send the completed, signed request to:**

Community Health Plan of Washington  
Attn: Compliance Department  
1111 3<sup>rd</sup> Ave, Ste. 400  
Seattle, WA 98101  
Fax: (206) 652-7006  
Email: [member.rights@chpw.org](mailto:member.rights@chpw.org)

If you have any questions or to obtain a full notice of your privacy rights, contact CHPW's Customer Service department at the following

AH\_CM589\_Request\_To\_Access\_PHI\_11\_2023  
H5826\_CP055\_Request\_to\_Access\_PHI\_11\_2023\_C  
CS\_CP157\_Request\_Access\_PHI\_11\_2023

HCA: 37441

<p><b>If you are a Washington Apple Health (Medicaid) Member</b></p> <p>Contact Customer Service toll-free at 1-800-440-1561, Monday – Friday, from 8am to 5pm.</p> <p>If you are hearing or speech impaired, please call TTY 711 (toll-free).</p> <p>The notice is also available online at: <a href="https://www.chpw.org/member-center/member-rights/">https://www.chpw.org/member-center/member-rights/</a></p>	<p><b>If you are a CHPW Medicare Advantage Member</b></p> <p>Contact Customer Service toll-free at 1-800-942-0247, 7 days a week, from 8am to 8pm.</p> <p>If you are hearing or speech impaired, please call TTY 711 (toll-free).</p> <p>The notice is also available online at: <a href="https://medicare.chpw.org/member-center/member-rights/">https://medicare.chpw.org/member-center/member-rights/</a></p>
<p><b>If you are a Cascade Select Member</b></p> <p>Contact Customer Service toll-free at 1-866-907-1906, Monday – Friday, from 8:00 a.m. to 5:00 p.m.</p> <p>If you are hearing or speech impaired, please call TTY 711 (toll-free).</p> <p>The notice is also available online at: <a href="https://individualandfamily.chpw.org/member-center/member-rights/">https://individualandfamily.chpw.org/member-center/member-rights/</a></p>	