Western Health Advantage

Access to Protected Health Information (PHI)

What is PHI?

Protected Health Information (PHI) means personally identifiable information about your physical or mental health or condition, the provision of health care to you and the payment for health care services.

What does the right to access PHI mean?

You or your personal representative have the right to inspect, review or get a copy of the information kept by Western Health Advantage (WHA) in the designated record set in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1996. The designated record set includes any records used to make decisions about you as a member. This set may include records about enrollment, claims, case management, medical management, or utilization management.

The right of access excludes psychotherapy notes, information WHA has compiled in anticipation of or for use in civil, criminal or administrative actions or proceedings, and certain other records exempted under federal privacy regulations.

How do I request access to my PHI and records?

Requests for access must be in writing. WHA prefers the use of our form, which is available at westernhealth.com/legal/privacy. Pursuant to HIPAA requirements, WHA will verify the identity of the person requesting access before the same is processed.

A copy of a photo ID of the member, personal representative and/or, as applicable, the PHI recipient, must be submitted with the form unless one is already on file with WHA.

Please complete the entire form, sign it and return it to us:

BY MAIL: Western Health Advantage Mail Service
Attn: Member Services
P.O. Box 4457, Portland, OR 97208-4457
If mailing, use only the post office box address listed above

BY FAX: Western Health Advantage
Attn: Member Services
916.678.5440

TO DELIVER IN PERSON: Western Health Advantage
2349 Gateway Oaks Drive, Suite 100
Sacramento, CA 95833

How much will this cost?

WHA does not charge for copies of records sent in electronic format. However, you may be charged a reasonable cost-based fee for supplies (e.g. CD), labor, postage and copying of the requested information

How will I know if my request is processed?

WHA will respond to your request within 30 days. If we cannot respond within 30 days, we will send you a written notice that it will take longer. Also, WHA may deny your request. If we deny your request, we will tell you in writing and let you know if and how you can appeal our decision.

Who do I call for more questions?

If you have any other questions or concerns you may contact the WHA Member Services Team at 916.563.2250 or 1.888.563.2250. If you are hearing impaired and use a Teletype (TTY) Device, please call our TTY line at 711. Customer Service assistance is available to answer questions, seven days a week, between 8 a.m. and 8 p.m. (Pacific Time).

Access to PHI Request Form

Western Health Advantage

Mail to: Western Health Advantage Mail Service, Attn: Member Services
PO Box 4457, Portland, OR 97208-4457
Fax to: 916.678.5440
Questions? 916.563.2250 | 888.563.2250 toll-free | 711 TTY

Member Name (First Last) _____

Date of Birth _____

WHA ID _____

Address _____

Phone No _____

Email _____

This form will allow a member to inspect or obtain a copy of Protected Health Information (PHI) in the designated record set, except for certain limited information such as psychotherapy notes, information WHA has compiled in anticipation of or for use in civil, criminal or administrative actions or proceedings, and certain other records exempted under federal privacy regulations.

Information Requested

Specific Records from _____ to _____ (limited to 6 years prior to date of request
(Month/Year) (Month/Year)

❑ **Enrollment Records**
- ❑ Application and related documents
- ❑ Coverage and dates of eligibility
- ❑ Change and termination of coverage documents

❑ **Case or Medical Management Records**
- ❑ Medical Management (e.g. utilization review)
- ❑ Case Management
- ❑ Appeals and Grievances
- ❑ Disease Management

❑ **Premium Payment Records**

❑ **Claims or Billing Records**
- ❑ Accumulator
- ❑ Claims History, including Pharmacy

❑ Other Personal Information used or maintained by WHA, specifically

_____

If the information requested will be sent to a designated Third Party, is the recipient also authorized to receive Sensitive Information as described below?

❑ NO ❑ YES If Yes, I specifically authorize WHA to release to Recipient:

❑ All sensitive information

OR ❑ Only the following information: (check all that apply)

❑ Alcohol/substance abuse
❑ Mental health
❑ Genetic information
❑ Sexually transmitted illness (including HIV/AIDS)
❑ Sexual, physical, or mental abuse
❑ Abortion/reproductive health (including pregnancy, contraception)

Format/Method

Inspection

❑ I prefer to inspect the requested information in person and will arrange for a mutually convenient time to come to the WHA office.

Copy

❑ Paper

❑ Electronic – please specify _____

❑ Please mail to:

❑ Me, at the address: ❑ on record with WHA or ❑ listed in this request

❑ Other/Third Party (please specify recipient name and complete address):

Name _____

Address _____

City State Zip _____

❑ I or my personal representative will pick up the copy at the WHA office.

Summary (Check one)

❑ I prefer to receive a written summary of the requested information. Please mail to:

❑ Me, at the address: ❑ on record with WHA or ❑ listed in this request

❑ Other/Third Party (please specify recipient name and complete address):

Name _____

Address _____

City State Zip _____

I understand and agree to the following:

- My request will be processed within thirty (30) days, or I will be informed in writing of the need for an extension of not more than 30 additional days to process the request. WHA will take reasonable efforts to produce the designated record in the form and format I requested. However, if WHA cannot produce the records in the form and format requested, a mutually agreeable alternative will be established.
- If I requested for a copy or summary, I will be responsible for paying a reasonable cost-based fee for supplies, labor, postage and copying and the requested information will be mailed to me via US postal mail at the address indicated above.
- This request for access to information may be denied or reduced and only portions released. If so, I have the right to request a review of this decision by a licensed health care professional that WHA designates, by submitting my request in writing to Western Health Advantage Mail Service, Attn: Member Services, PO Box 4457, Portland, OR 97208-4457.
- I may file a complaint concerning my request for access to the Privacy Officer, Western Health Advantage, 2349 Gateway Oaks Dr., Suite 100, Sacramento, CA 95833, or to the US Department of Health & Human Services at 200 Independence Avenue, S.W. Room 509F HHH Bldg., Washington, D.C. 20201
- This request must be accompanied by a copy of a photo ID of the member and the recipient, unless one is already on file with WHA.
- If you send a completed form by email to WHA, you acknowledge that it is not best practice to send protected health information through email that is not secure.

MEMBER NAME (PRINT) _____

MEMBER SIGNATURE _____ DATE _____

Personal Representative

NAME (PRINT) _____

SIGNATURE _____ DATE _____

Please check the box that describes your relationship to the member:

❑ Parent of Minor ❑ Legal guardian ❑ Power of Attorney ❑ Executor ❑ Other

Documentary proof of your relationship/authorization must be attached to this request. If you are requesting the access for a minor 12 years of age or older, federal and state laws may prohibit WHA from acting on your request about information relating to sensitive services without written authorization from the minor.

WHA Internal Use Only

Date Request Received _____ ❑ Identification Verified (documents checked)

Signature of Manager or Supervisor _____

Printed Name _____