



<Blue Cross Community MMAI> Request for Records
(Request form to get copies of your records)

Please fill out this form if you want to look at or get copies of your records from <Blue Cross Community MMAI>.

WHEN COMPLETED AND SIGNED, PLEASE MAIL OR EMAIL TO:

**c/o Privacy Office
Blue Cross Community MMAI
P.O. Box 660044
Dallas, TX 75266-0044
OCA_SSD@bcbstx.com**

Part A: Please tell us about the person whose records you are asking for.

Member Name: <_____>

Address: <_____>

City: <_____> State: <_____> ZIP: <_____>

Phone Number: <_____>

Date of Birth: <_____>

Member ID Number: <_____>

You have the right to look at and get a copy of your records from Blue Cross Community MMAI. You may not be able to get a copy of any of these:

- *Psychotherapy notes that we may have on file,*
- *Any information we have put together for use in a court of law,*
- *Any information that we do not have to give you based on what the law says, or*
- *Certain other records.*

Part B: Please check the box below to tell us which records you want to look at or get copies of:

☐ **Enrollment/disenrollment/billing** – used to sign up for or leave a health plan or, apply premiums

☐ **Medical management/provider appeals** – used to approve services ahead of time

☐ **Claims** – records we have for claims that were paid or denied

☐ **All Member appeal files** – used in the appeal process

☐ **Other** – please list the records you want copies of and the time period the information covers

Date(s):

<_____> To <_____>

Part C: Please tell us how you would like to get or look at the records you requested (check the box below that applies).

Send my PHI to: (select only one)

☐ Me

☐ Designated Third party: I request that Blue Cross Community MMAI send my PHI as specified in Section B above directly to the designated third party listed below.

Name	Address	City	State	ZIP	Phone Number
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Format/Manner: (select only one)

☐ Send electronic copy. Note: Information will be sent to the email address provided below via secured (encrypted) email unless otherwise specified. **Email address:**

☐ Send paper copy of information via US Mail

☐ View in person. I understand that I or my designee will be contacted to arrange for this.

We will make copies for everyone on your list.

- You must give us a signed authorization (approval) form if you want us to let someone other than the person you have named as your chosen legal representative to look at or get copies of your records.
- We can give you the right form to do this. Call Member Services at **1-877-723-7702** (TTY **711**). We are available seven (7) days a week. Our call center is open Monday-Friday 8:00 a.m. – 8:00 p.m. Central time. On weekends and Federal holidays, voice messaging is available. If you leave a voice message, a Member Services representative will return your call no later than the next business day. The call is free.

Part D: Member's signature

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Member's signature

Date

Chosen legal representative or guardian

If the member chose someone to sign this form for him or her, that person needs to fill out the lines below. And please attach a copy of a Health Care Power of Attorney, a court order or other papers that show that this person may act for the Member.

Legal representative or guardian (print full name): <_____>

Legal relationship to the member: <_____>

Signature: <_____> Date: <_____>

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call Member Services at 1-877-723-7702 (TTY/TDD: 711). We are available seven (7) days a week. Our call center is open Monday-Friday 8:00 a.m. – 8:00 p.m. Central time. On weekends and Federal holidays, voice messaging is available. If you leave a voice message, a Member Services representative will return your call no later than the next business day. The call is free.

ATENCIÓN: Si habla español, los servicios de asistencia lingüística están a su disposición sin costo alguno para usted. Llame al 1-877-723-7702 (TTY/TDD: 7-1-1). Estamos a su disposición los siete (7) días de la semana. Nuestra central telefónica está abierta de lunes a viernes de 8:00 a. m. a 8:00 p. m., hora del centro. Para los fines de semana y días feriados federales, está disponible el servicio de mensajes de voz. Si deja un mensaje de voz, un representante de Atención al Asegurado le devolverá la llamada antes del próximo día laborable. La llamada es gratuita.

Blue Cross Community MMAI (Medicare-Medicaid Plan) is provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association. HCSC is a health plan that contracts with both Medicare and Illinois Medicaid to provide benefits of both programs to enrollees. Enrollment in HCSC's plan depends on contract renewal.

Blue Cross and Blue Shield of Illinois complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross and Blue Shield of Illinois does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Illinois:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Civil Rights Coordinator.

If you believe that Blue Cross and Blue Shield of Illinois has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35th floor, Chicago, Illinois 60601, 1-855-664-7270, TTY: 1-855-661-6965, Fax: 1-855-661-6960, Civilrightscoordinator@hcsc.net. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-877-723-7702 (TTY/TDD: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-723-7702 (TTY/TDD: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-723-7702 (TTY/TDD: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-723-7702 (TTY/TDD: 711)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-723-7702 (TTY: TTY/TDD) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-723-7702 (TTY/TDD: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-723-7702 (رقم هاتف الصم والبكم: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-723-7702 (телетайп: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિઃશુલક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-877-723-7702 (TTY/TDD: 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 1-877-723-7702 (TTY/TDD: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-723-7702 (TTY/TDD: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-723-7702 (TTY/TDD: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-723-7702 (TTY/TDD: 711) पर कॉल करें।

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-723-7702 (ATS: 711).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-877-723-7702 (TTY/TDD: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-723-7702 (TTY/TDD: 711).