Banner | aetna

Protected Health Information (PHI) Access Request Form

This form needs to be completed and signed, where appropriate, for Banner|Aetna to process the request. If you want to receive information for more than one Member, please submit a separate, completed form for each Member.

1. Member Information (Information About Person Whose Records are Being Requested.)

Last Name		First Name		Middle Initial
I.D. Number	Social Security Number	Birth Date *(MM/DD/YYYY)*	Daytime Telephone Number *(include area code)*	
Street Address		City, State and ZIP Code		

2. Subscriber Information

(The Subscriber is usually the employee who obtains coverage for his or her family. Please complete this Section if the Subscriber is not the Member whose records are being requested.) This Section does not apply to Long Term Care.

Last Name		First Name		Middle Initial
I.D. Number	Social Security Number	Birth Date *(MM/DD/YYYY)*	Daytime Telephone Number *(include area code)*	
Street Address		City, State and ZIP Code		

3. Description of PHI Access Reports

Upon receipt of this signed PHI Access Request Form, we will provide a PHI Access Report containing the most recent 24 months of on-line medical, dental, and pharmacy claim data that we have in our possession. If this PHI Access Report is sufficient, you do not need to select any of the options in this Section but you must complete Section 4 or 5, whichever applies to this request. Indicate below if you have a more specific request.

If instead of the most recent 24 months of claim data, you prefer for the PHI Access Report to include claim data over a different period, please indicate the date range below:

From: _____ To: _____

If you receive reimbursements for medical expenses through a Flexible Spending Account (FSA) administered by Aetna and would like a report of FSA payments sent, please check the appropriate box below, complete the rest of this PHI Access Request Form (including the necessary signature in Section 4 or 5, whichever applies), and, in addition, have the Subscriber or the Subscriber's Legal Representative sign the authorization in Section 4 or 5, as appropriate.

☐ I want the PHI Access Report to include FSA information ☐ I only want FSA information sent

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If you receive benefits from Aetna's Long Term Care (LTC) plan and would like LTC information sent, please check the appropriate box below:

☐ I want the PHI Access Report to include LTC information ☐ I only want LTC information sent

Important Notice to Individual(s) signing this PHI Access Request Form:

- The PHI Access Report provided in response to this request may include diagnosis and treatment information, such as information on chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, sexually-transmitted diseases, HIV/AIDS, and/or genetic marker information.
- Any requested Flexible Spending Account (FSA) information will include information for all of the Subscriber's covered dependents.

4. If the PHI Access Report is to be sent to the Member, the Member's Legal Representative or the Member's Parent if the Member is an unemancipated minor child, the recipient must complete Section 4.

The recipient of the PHI Access Report is: ☐ Member ☐ Member's Legal Representative ☐ Member's Natural or Adoptive Parent (authorized by law to act on behalf of the unemancipated minor child identified in Section 1)

Signature of Recipient	Date
Print Name of Recipient	
Recipient's Street Address	City, State and ZIP Code
Signature of Subscriber or Subscriber's Legal Representative ***(required if FSA information is to be included)***	Date
Print Name of Subscriber's Legal Representative *(if applicable)*	

If this request is signed by the Member's Legal Representative or the Subscriber's Legal Representative, you must furnish a copy of the health care power of attorney or other relevant document legally authorizing the Legal Representative to act on behalf of the Member or Subscriber, as applicable.

5. Authorization for Release of PHI (to be completed if the PHI Access Report is to be sent to someone other than the Member, the Member's Legal Representative, or the Member's Parent if the Member is an unemancipated minor child)

I hereby authorize Banner|Aetna Insurance Company and/or, Banner|Aetna Plan, Inc., and any of its parents, subsidiaries, affiliates and their respective employees, agents and subcontractors, to disclose PHI concerning the Member identified below.

Signature of Member, Member's Legal Representative, or the Member's Natural or Adoptive Parent (authorized by law to act on behalf of the unemancipated minor identified in Section 1)	Date
Print Name of Member, Member's Legal Representative, or Member's Parent	
Signature of Subscriber or Subscriber's Legal Representative ***(required if FSA information is to be included)***	Date
Print Name of Subscriber's Legal Representative *(if applicable)*	

Authorized Recipient's Last Name	First Name	Middle Initial
Authorized Recipient's Street Address	City, State and ZIP Code	

6. How to Return This Form

Return this completed form to: HIPAA Member Rights Department
PO Box 14079
Lexington, KY 40512-4079
Fax: 859-280-1272

Please allow 30 days for our response.

Nondiscrimination Notice

Banner|Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

We provide free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator
P.O. Box 14462, Lexington, KY 40512
1-800-648-7817, TTY: 711
Fax: 859-425-3379
E-mail: **CRCoordinator@aetna.com**

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Banner|Aetna is the brand name used for products and services provided by Banner Health and Aetna Health Insurance Company and Banner Health and Aetna Health Plan Inc. Health benefits and health insurance plans are offered and/or underwritten by Banner Health and Aetna Health Insurance Company and/or Banner Health and Aetna Health Plan Inc. (Banner|Aetna). Each insurer has sole financial responsibility for its own products. Banner Health and Aetna Health Insurance Company and Banner Health and Aetna Health Plan Inc. are affiliates of Banner Health and, of Aetna and its affiliates (Aetna). Aetna provides certain management services to Banner|Aetna.

TTY: 711

To access language services at no cost to you, call the number on your ID card.

Para acceder a los servicios de idiomas sin costo, llame al número que figura en su tarjeta de identificación. (Spanish)

T'áá ni nizaad k'ehjí bee níká a'doowoł doo bą́ąh ílínígóó naaltsoos bee atah nílį́įgo nanitinígíí bee néého'dólzinígíí béésh bee hane'í bikáá' áajį' hólne'. (Navajo)

如欲使用免費語言服務，請致電您 ID 卡上的電話號碼 (Chinese)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số điện thoại ghi trên thẻ ID (Nhận dạng) của quý vị. (Vietnamese)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم الموجود على بطاقتك الشخصية. (Arabic)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tawagan ang numero sa inyong ID card. (Tagalog)

무료 언어 서비스를 이용하려면 보험 ID 카드에 수록된 번호로 전화해 주십시오. (Korean)

Afin d'accéder aux services langagiers sans frais, veuillez composer le numéro inscrit sur votre carte d'identité. (French)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie die Nummer auf Ihrer ID-Karte an. (German)

Для получения бесплатной помощи переводчика позвоните по телефону, указанному на Вашей личной карточке медицинского страхования. (Russian)

言語サービスを無料でご利用いただくには、IDカードに記載の番号にお電話ください。
(Japanese)

برای دسترسی به خدمات زبان به طور رایگان، با شماره قید شده روی کارت شناسایی خود تماس بگیرید. (Persian-Farsi)

ܐܢ ܗܫܒܩܐ ܬܠܘܢ ܥܠ ܡܠܚܡܘܬܐ ܕܬܪܓܡܢܘܬܐ ܕܠܫܢܐ ܡܓܢܐܝܬ، ܩܪܘܢ ܡܢܝܢܐ ܥܠ ܦܬܩܐ ܕܡܙܕܗܝܢܘܬܐ ܕܝܘܟܘܢ.
(Syriac-Assyrian)

Za besplatne prevodilačke usluge pozovite broj naveden na Vašoj identifikacionoj kartici.
(Serbo-Croatian)

หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทรหมายเลขที่แสดงอยู่บนบัตรประจำตัวของท่าน (Thai)