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's "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 benefits management record systems used to make decisions about individuals.

The period of service for the Designated Record Set being requested is _____ to _____.
(date in mm/dd/yyyy format) (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 (specify below)

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 agree to pay any fees for labor involved in copying my health information, whether in paper or electronic form. Fees will be reasonable and cost-based. Electronic copies not to exceed $40 per hour and costs for physical copies include 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.

I understand that this request does not require release to me of certain health information, including:

(1) information that is not held in the Designated Record Set; (2) psychotherapy notes or substance use disorder treatment 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.

Name	**Daytime Phone Number**	**Member ID or Social Security number**	
Street or PO box	**City**	**State**	**ZIP**

Signature

Date signed (mm/dd/yyyy)

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