HIGHMARK | HIGHMARK

Request to Access Protected Health Information (PHI)

Highmark Blue Cross Blue Shield, Highmark Blue Shield & Affiliated Health Plans**

Please return completed form to:
Highmark, Inc
Customer Service
PO Box 890035
Camp Hill, PA 17089

Please complete all fields. If information is missing, we will return the form to you for completion. If you need help with this form, contact the Customer Service number listed on your member identification card.

MEMBER INFORMATION - (Please PRINT the information for the member whose PHI is being requested.)

Member Name:		Date of Birth:
Address:		
City:	State:	Zip:
Phone (Daytime):		Member ID:

REQUEST DELIVERY METHOD - (Choose how you would like to receive the information.)

- ☐ Mail to address above
- ☐ View records onsite (*A Highmark staff member will contact you to arrange a review date and time.)*
- ☐ Secure email to:_____

INFORMATION REQUESTED- (Choose the information you wish to receive. Check all that apply.)

Requested dates of service* | From ____ / ____ /____ to ____ / ____ / ____
(*if no date is specified records from the last 90 days will be provided)

- ☐ ALL ENROLLMENT INFORMATION or
  - ☐ Application information ☐ Coverage Information (Dates, termination, changes)
- ☐ ALL CLAIMS INFORMATION or
  - ☐ Accumulator information ☐ Claims history, including Pharmacy
- ☐ ALL MANAGED CARE INFORMATION or
  - ☐ Care Coordination ☐ Case Management ☐ Appeals & Grievances ☐ Disease Management
- ☐ Payment Information ☐ Explanation of Benefits ☐ Clinical Records
- ☐ All Records ☐ Other(specify):

I am requesting access to my protected health information (PHI) that Highmark and its subsidiaries and affiliates (Highmark) maintains in a set of specific record(s). I understand that:

- I am not entitled to records that are not maintained within the Highmark designated record set;
- I am not entitled information compiled for use in civil, criminal, or administrative action or proceeding;
- If Highmark cannot produce the records in the format requested, an agreed upon alternative will be identified.

_____ _____
Signature of Member or Personal Representative* Date

_____ _____
Printed name of Member or Personal Representative Relationship to Member

* If you are signing this form as a legal representative for the member, you must attach copies of your authorization as required by state law to represent the member (e.g., healthcare power of attorney, healthcare surrogate, or guardianship papers).

Disclosures:

Benefits and/or benefit administration may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association:

Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life, Highmark Senior Health Company, Highmark Care Benefits Inc., or Gateway Health Plan, Inc. d/b/a Highmark Wholecare.

Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company, Highmark Senior Health Company, or Gateway Health Plan, Inc. d/b/a Highmark Wholecare.

PA: Your plan may not cover all your health care expenses. Read your plan materials carefully to determine which health care services are covered. For more information, call the number on the back of your member ID card or, if not a member, call 866-459-4418.

Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield or Highmark BCBSD Health Options Inc. d/b/a Highmark Health Options.

West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company, Highmark Senior Solutions Company, or Highmark Health Options West Virginia Inc. d/b/a Highmark Health Options and Highmark Blue Cross Blue Shield. Visit https://www.highmarkbcbswv.com/networkaccessplan to view the Access Plan required by the Health Benefit Plan Network Access and Adequacy Act. You may also request a copy by contacting us at the number on the back of your ID card.

Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield.

Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to “Highmark” in this document are references to the Highmark company that is providing the member’s health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.