

Request for Copy of Protected Health Information

1. MCHA Member information (person whose information will be disclosed)

Member Name: _____ Date of Birth: (mo/day/year) ____/____/____

Mailing Address: _____

Group/Policy #: _____ 9 Digit ID #: _____

Telephone Number: _____

2. Mailing Address (place where the information will be sent)

Name: _____

Mailing Address: _____

City/State/Zip: _____

3. Information requested (call your clinic directly if you need to request medical records)

Identify the dates for the protected health information you are requesting.

From: _____ to _____

Check the box next to the protected health information you are requesting a copy of.

Membership information (for example: dates of coverage, address, date of birth)

Please describe: _____

Medical claims information (for example: claims summary)

Please describe: _____

Pharmacy claims information (for example: claims summary)

Please describe: _____

Appeal information (for example: appeal letters or appeal records)

Please describe: _____

Other information: Describe protected health information you are requesting a copy of

4. Signature required of member or personal representative:

- If the member is 18 or older, they must sign this form.
- If signed by a personal representative, also submit a copy of legal authorization (for example: power of attorney, legal guardian, foster parent).

Signature of member or personal representative: _____ Date: _____

Personal representative's relationship to member: _____

Return completed form to:

MCHA /Medica Customer Service, Mail Route 0501, PO Box 9310, Minneapolis, MN 55440-9310
Fax # 952-992-3198

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