Form F10: Record Access Request Form

Use this form to exercise your right under federal privacy laws to request to inspect or obtain copies of your protected health information contained in our designated record set or the designated record sets of our business associates. This form consists of three (3) pages. Please Print.

Section A: Individual requesting access.

Member Name: _____ Date of Birth: _____

BCBSVT ID Number: _____

Address: _____

_____

Telephone: _____ E-Mail Address: _____

Section B: Please read the following and complete the information requested:

You have the right to inspect and obtain a copy of your protected health information in designated record sets we or our business associates maintain. You are not, however, entitled to inspect or obtain a copy of any psychotherapy notes we may have, any information we may have compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding, any information not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a), and certain other records. We will provide you with copies of the information you request free of charge. To exercise your right of access, please complete this Section and return the completed form to Blue Cross and Blue Shield of Vermont, Attn: Privacy Officer, PO Box 186, Montpelier, VT 05601-0186, or privacyofficer@bcbsvt.com.

Do you wish to (check one):

□ Inspect these records (We will contact you to set up an appointment to visit our office)

□ Obtain copies of these records (This service is offered free of charge)

Format Requested: _____

Deliverty Instructions:

If you are requesting copies, please provide the contact details for the format indicated above:

❑ United States Postal Service (USPS):

_____

Name Address City State Zip Code

❑ Secure E-mail: _____

❑ Fax: _____

Please briefly state the reason for this request: _____
_____

Optional – Authorized Individual: if you would like BCBSVT provide access to or copies of your records to any person other than you or your personal representative, you must sign a Form F1: Authorization to Release Information (or Form F1A: Authorization to Release Information Following Termination of Coverage). Please complete the following fields for the authorized person:

The Authorized Individual May (check one):
□ Inspect these records (We will contact them to set up an appointment to visit our office)
Preferred method of contact for authorized individual: _____
□ Obtain copies of these records (This service is offered free of charge)
Format Requested: _____

Deliverty Instructions to Authorized Individual:
If you are requesting copies to be sent to the authorized individual, please provide the contact details for the format indicated above:
❑ United States Postal Service (USPS):

_____
Name Address City State Zip Code

❑ Secure E-mail: _____

❑ Fax: _____

Please specify the records you wish to inspect or obtain copies of by checking the box next to the item (Check all that apply):

Enrollment Information **Time Period From ___/___/___ To ___/___/___**
□ Enrollment Application
□ Contract (Certificate of Coverage, Outline of Coverage and applicable Riders and Endorsements)

Complaints/Appeals (if any) **Time Period From ___/___/___ To ___/___/___**
□ First Level Appeal Documents
□ Second Level Appeal Documents
□ Supporting Documents

Eligibility Information **Time Period From ___/___/___ To ___/___/___**
□ Membership Records
□ Billing Information (Non-group Enrollment Only)

Claims Information **Time Period From ___/___/___ To ___/___/___**
□ Specific Provider _____
□ Comprehensive Explanation of Benefits (this will list all claims incurred, the provider name, date of service, whether the claim paid, amount charged, allowed amount, amount paid, date paid deductible and coinsurance information)
□ Copies of Claims (please check the type(s) of claims you are requesting):

□ Medical (includes HIV/AIDS and Sexually Transmitted Diseases)
□ Mental Health/Substance Use Disorder (SUD) Records
□ Pharmacy

Benefit Information (if any) **Time Period From ___/___/___ To ___/___/___**
□ Coordination of Benefits information
□ Pre-Existing Health Condition Information
□ Case Management Information
□Clinical Information/Medical Records (excluding any psychotherapy notes)
□ Utilization Review Records (includes Prior Approval information and Referrals, if applicable)

Section C: Individual's Signature

Signature: _____ Date: _____

If you are a personal representative, such as a Legal Guardian or an agent acting under a Power of Attorney, you *may* be able to sign on behalf of the Member if the supporting documentation has the required language. This Form shall be accompanied by such supporting documentation for BCBSVT's Legal Department to determine whether authority is granted to authorize this Form.

Personal Representative's Name: _____

Relationship to Member or Authority to act as Personal Representative: _____

YOU ARE ENTITLED TO A COPY OF THIS REQUEST