WPS HEALTH SOLUTIONS WPS HEALTH INSURANCE Arise HEALTH PLAN EPIC SPECIALTY BENEFITS

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

You have the right to request access to protected health information about you that is maintained by Wisconsin Physicians Services Insurance Corporation (WPS or WPS Health Insurance), and/or its wholly owned subsidiaries, The EPIC Life Insurance Company (EPIC Specialty Benefits), and WPS Health Plan, Inc. (Arise Health Plan) (hereinafter "WPS Health Solutions"). WPS Health Solutions will evaluate your request and will either grant your request or explain the reason why the request will not be granted no later than thirty (30) days from receipt of your request. WPS Health Solutions may charge you a reasonable cost-based fee for your request. Your right to access does not extend to information complied in reasonable anticipation of litigation; psychotherapy notes; information not maintained by WPS Health Solutions; or other information not subject to the right of access under the Health Information Portability and Accountability Act (HIPAA) Privacy Rule.
***NOTE: WPS Health Solutions does not maintain original medical records. We advise members to contact their provider's office, clinic or hospital to obtain medical records. Members must follow the provider's procedures for accessing medical records.**

PART A: MEMBER INFORMATION

Member Last Name	Member First Name	M. I.	Member Date of Birth
Member Street Address	City	State	Zip Code
Phone # (including area code)	Cell Phone# (including area code)	Subscriber Number (ID Card)	

PART B: SCOPE OF ACCESS REQUEST

In accordance with the HIPAA Privacy Rule, I request a copy of my protected health information (PHI) held by WPS Health Solutions for the following dates:_____

I request protected health information (PHI) contained in the following records: *(please check all that apply)*

☐ Designated Record Set* ☐ Enrollment ☐ Customer Service ☐ Premium/Contribution Payment ☐ Case or Medical Management

☐ Claims, Billing and EOB Information relating to the following service or claim: (specific date and/or medical claim):

_____

☐ Other:_____

*NOTE: Designated record set has the same meaning as set forth in the HIPAA Privacy Rule, limited to enrollment, payment, claims adjudication and case or medical management records systems maintained by WPS Health Solutions or used, in whole or in part, by WPS Health Solutions to make decisions about an individual. NOTE: Information used in quality control efforts-not for coverage determinations-is NOT part of the designated record set because it is not used to make decisions about people.

PART C: FORM, FORMAT & MANNER OF ACCESS REQUEST

☐ **Inspection.** I would like to inspect the above information at WPS Health Solutions during regular business hours (8:00 am - 4:30 pm). If my request is granted, please:

☐ **Call me via telephone** (at the number listed above) OR ☐ **mail me a letter** (at the address listed above) to let me know when I may come to WPS Health Solutions to inspect the information.

☐ **Paper Copies.** I would like paper copies of the requested information:

☐ **mailed to me** at mailing address listed above ☐ **mailed to me** at a different mailing address *(please provide the information here):*

_____

☐ **Digital Copies.** I would like digital copies (CD/DVD) of the requested information.

☐ **mailed to me** at mailing address listed above ☐ **mailed to me** at a different mailing address *(please provide the information here):*

_____

☐ **Electronic Copies.** I would like electronic copies of the requested information **emailed to me** at the following email address:

_____

By requesting electronic copies and signing this form, I acknowledge that I am aware of and assume the risks associated with transmitting unencrypted email, including that it may be intercepted, forwarded, printed and stored by others. I understand that WPS Health Solutions is not responsible for unauthorized access of PHI while in transmission to me or the third-party I direct and is not responsible for safeguarding my information once it is delivered to me or the third party I direct.

☐ **Summary.** I would prefer to receive a written summary of the requested information instead of the complete record.

*I understand that I may be charged a fee for copying and for any supplies (including CD/DVD) used to create the copy and postage fees for transmitting the information I have requested.

PART D: MEMBER SIGNATURE OR AUTHORIZED REPRESENTATIVE/GUARDIAN

Member signature or Designated Legal Representative/Guardian signature **X**	**Date**

If authorized representative: (1) print your name, (2) state the legal authority for your status as Member's representative, and (3) attach supporting documentation:

Email: WPSprivacyofficer@wpsic.com **Mail:** Legal/Privacy, P.O. Box 8190, Madison, WI 53708-8190 **Fax:** (608) 977-9885