HealthSpring℠

REQUEST TO ACCESS HEALTH RECORDS

Use this form to request a copy of your Protected Health Information in a Designated Record Set that HealthSpring or one of its Business Associates maintains. If you need assistance completing the form, contact the Customer Service number listed on your Member Identification Card. You must complete all the fields on this form.

WHEN COMPLETED AND SIGNED PLEASE MAIL TO YOUR PLAN'S CORRESPONDING ADDRESS BELOW:

Medicare Advantage Plan:
HealthSpring
Medicare Advantage Privacy Rights Intake and Management
PO Box 24207
Nashville, TN 37202

Medicare Prescription Drug Plan:
HealthSpring
Medicare Prescription Drug Plan
PO Box 269005
Weston, FL 33326-9927

Section A The individual for whom access is being requested. Please complete the following:

First Name _____ Last Name _____ Group Number _____

Social Security Number _____ Date of Birth _____ Identification\Subscriber Number _____

Address _____ City _____ State _____ Zip _____

Area Code & Telephone Number _____

Section B Please place an "X" in the box next to the records you wish to inspect or obtain a copy of and indicate specific dates:

Enrollment Records	From:	To:	Health Records	From:	To:
☐ Application/Underwriting/Attending Physician Statement Record	_____	_____	☐ Medical	_____	_____
			☐ Dental	_____	_____
☐ Premium Payment/Billing History (if applicable)	_____	_____	☐ Prescription Drugs	_____	_____
			☐ Vision	_____	_____
			☐ Mental Health	_____	_____

This Request CANNOT be used to disclose Psychotherapy Notes or phone records that are not part of the Designated Record Set.

Section C By placing an "X" in the appropriate boxes below please indicate who and in which format/manner you wish to receive/review your information.

Send my PHI to: (select only one)

☐ Me

☐ Designated Third Party: I request that HealthSpring send my PHI as specified in Section B above directly to the designated third party listed below.

Name _____ Address _____

City _____ State _____ Zip _____ Phone Number _____

Format/Manner: (select only one)

☐ Send electronic copy. Note: Information will be sent to the email address provided below via secured (encrypted) email unless otherwise specified.

Email address: _____

☐ Send paper copy of information via US Mail.

☐ View in person. I understand that I or my designee will be contacted to arrange for this.

Section D Signature: This document must be signed by the individual, parent of minor child or the individual's Personal Representative.

I request that HealthSpring provide access to my PHI as specified. I understand that I can only sign on behalf of a minor child under the age of 18, unless there is proof of legal guardianship.

Signature _____ Date: month/day/year _____

Section E If Section D is signed by a Personal Representative, please complete the information below:

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator, please attach a copy of the Legal documents. You do **NOT** have to attach copies of these documents if they are already on file with HealthSpring.

Personal Representative's Name _____ Relationship to Individual _____

Personal Representative's Address _____ City _____ State _____ Zip _____

Personal Representative's Area Code & Telephone Number _____

Personal Representative's E-mail Address (if available) _____

Any changes to the format, content or branding of this form are strictly prohibited without review and approval of the Privacy Office.