



# Request for an Accounting of Disclosures of Protected Health Information (PHI)

Protected Health Information (PHI) means information about your health. This form must be completed and signed to process this request.

## 1. Who is the Medicaid Member?

First name		Last name	Middle initial
Member ID number	Birthdate (MM/DD/YYYY)		Phone number
Street			
City, state, ZIP code			

## 2. Description of the Accounting Report

Once we get this signed request form, we will send you the Accounting Report. The disclosures on the report are for reasons other than "treatment," "payment," or "health care operations."

## 3. Accounting Report time period cannot be longer than six (6) years from the request date.

My request is for the dates below:

\_\_\_\_\_ to \_\_\_\_\_

MM/DD/YYYY MM/DD/YYYY

## 4. Where do you want this Accounting Report to be sent?

Who is receiving this Accounting Report?

Member     Member's Legal Representative     Member's Natural or Adoptive Parent

Print name of recipient

Recipient's street address

City, state, ZIP code

