



HIPAA PRIVACY COMPLAINT FORM

This form is for the use by a West Region beneficiary to submit an inquiry or complaint about TriWest Healthcare Alliance (TriWest) HIPAA Privacy policies or practices.

SECTION A: Individual Submitting Inquiry or Complaint

Name:			
Address:			
Telephone:		Email:	
Social Security Number:			

TO THE BENEFICIARY: PLEASE READ THE FOLLOWING AND PROVIDE THE REQUESTED INFORMATION

You have the right to file a privacy complaint with TriWest or with the Secretary of the Department of Health and Human Services (DHHS). You do not need to notify us prior to filing a complaint with DHHS.

You may use this form to file a complaint about all issues relating to the privacy practices of TriWest, including the use and disclosure of protected health information (PHI), denial of access to PHI and the denial of a request to amend records. TriWest will research your complaint and respond with the results of its evaluation.

SECTION B: DESCRIPTION OF COMPLAINT

Please select one: Inquiry Complaint

Please provide a concise statement of your inquiry or complaint.

What resolution do you seek from submitting your inquiry or complaint?

I certify that the statements made in this inquiry or complaint are true and correct to the best of my knowledge.

SIGNATURE:

Date:

If submitted by a personal representative on behalf of the beneficiary, complete the following:

Personal Representative's Name:

Relationship to Beneficiary:

Please submit the completed and signed request to:

TriWest Healthcare Alliance
Attn: HIPAA Privacy Official
P.O. Box 2585
Virginia Beach, VA 23450
Fax: 877-875-1340