HIPAA REQUEST FOR RECORDS

This information allows TriWest Healthcare Alliance (TriWest) to process a West Region beneficiary's request for a copy of records as contained in a designated record set maintained by TriWest or one of its business associates.

SECTION A: Individual/Beneficiary Information

Name:		
Address:		
Telephone:		Email:
Date of Birth:		Social Security Number:
Beneficiary DoD Benefits Number (DBN):		

SECTION B: I am requesting the following record copies.

Note: TriWest does not maintain provider medical records. Please contact the provider or facility that rendered the care for this information. You may not have the right to access psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a legal proceeding; or certain other records.

If reproduction costs exceed $30, TriWest may impose charges. You will be contacted if charges apply.

- Authorizations/Referrals
- Case/Care management records (behavioral health, physical health, ECHO)
- Disease management program records (anxiety, asthma, CHF, COPD, depression, diabetes)
- Enrollment payment/fee history
- Explanations of Benefits (EOB)
- Other: ______________________________

SECTION C: I am requesting copies for the following dates of service.

Note: TriWest maintains records six years from date of service. Records created prior to this date may not be available. Requests for records are generally completed within 30 calendar days; however, an extension may be requested.

From Date (MM/DD/YYYY):	To Date (MM/DD/YYYY):

SECTION D: I would like to receive the record copies by:

- Electronic copy (of information maintained within an electronic health record), if available. You must provide an email address in Section A. Any information we send will be encrypted.
- Paper copy by U.S. Postal Service Certified Mail or Parcel Service.

Optional:

- Please send my records to the person designated below (an additional HIPAA compliant Authorization for Disclosure form may be required).

Name:	
Address:	
Relationship to the beneficiary:	

SIGNATURE OF BENEFICIARY OR AUTHORIZED REPRESENTATIVE: Date:

TriWest Classification: Proprietary and Confidential

If this request is by a personal representative on behalf of the beneficiary, complete the following:
Personal Representative's Name:
Relationship to Beneficiary:
YOU ARE ENTITLED TO A COPY OF THIS REQUEST.

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