STATE OF LOUISIANA
DIVISION OF ADMINISTRATION
OFFICE OF GROUP BENEFITS

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

I hereby request access to my protected health information for the purpose of inspection and/or obtaining copies:

Health plan member/dependent name: _____

Date of Birth: _____

Address: _____

Telephone: _____
(primary number) *(alternate number)*

Member ID number: _____

The documents requested are:

☐ Claims ☐Remittance Records ☐Correspondence

Other (specify): _____

The requested record dates are, or date range is:

Dates: _____

I understand that this request legally may be denied under certain limited circumstances but that, if it is denied, I will be advised in writing of the basis for the denial.

If my request for access is approved, I understand that I have the right to inspect the electronic version of these records at an OGB office. [Add details about logistics of inspection of electronic version, unless waived, plus logistics/cost of obtaining copies/faxes, summaries and explanations.]

_____

Signature of Health Plan Member/Dependent or Representative Date

Request Approved:

Records to be furnished for inspection and/or copying:

Signature of the OGB Reviewer Date

Request Denied:

Reason:

Signature of the OGB Reviewer Date