WELL SENSE HEALTH PLAN

wellsense.org | 877-957-1300

Well Sense Health Plan Request for Access to Information Form

Please Note: This form is used to request a copy of your member information from Well Sense Health Plan. Your information includes, but is not limited to, your medical claims, pharmacy claims, co-payments, case management information, vision claims and behavioral health claims. The record does not include medical records. You may request medical records directly from your medical providers. All fields are required. Incomplete or incorrect forms will be returned.

Member Information (Please print information clearly)

YOUR MEMBER ID NUMBER (FOUND ON YOUR WELL SENSE HEALTH PLAN ID CARD)			
MEMBER'S LAST NAME			
FIRST NAME	MIDDLE INITIAL		
ADDRESS	CITY	STATE	ZIP CODE
PHONE			

Information being Requested

Please describe the <u>type</u> of information you are requesting.

<u>Please also check one of the three boxes below:</u>

☐ I am only interested in accessing or obtaining a copy of Requested Information relating to the time period _____ through_____.

☐ I am only interested in accessing or obtaining a copy of all Requested Information maintained by Well Sense Health Plan.

☐ I would prefer to receive the Requested Information in the form of a summary prepared by Well Sense Health Plan at a cost to me of <u>$0.</u>

I understand that any information provided to me pursuant to this request will not include psychotherapy notes, information compiled in reasonable anticipation of (or for use in) a civil, criminal or administrative proceeding or other information limited or restricted by applicable law. If I am a parent or legal guardian requesting access to a minor's information, I further understand that I may not be provided access to records related to certain categories of treatment as required by law.

I understand that Well Sense Health Plan may deny this request under limited circumstances as provided for under federal and state law protecting the privacy of health information. I further understand that, except as otherwise permitted under applicable law. I have the right to have a denial of my request reviewed by a licensed health care practitioner selected by Well Sense Health Plan who did not participate in Well Sense's decision to deny my request.

I understand that Well Sense Health Plan will notify me of its decision to approve or deny my request to access or obtain a copy of the Requested Information within thirty (30) days of receiving this request.

Method to Receive Information

Please provide the Requested Information to me in (please check the appropriate boxes).

☐ Electronic form;

☐ Paper form;

☐ Pick-up or view the Requested Information at a mutually agreeable time and place; OR

☐ Have the Requested Information mailed to me at the following address (if different than address above, write below).

_____

I understand that Well Sense will charge me $0 per page for the copying services necessary to complete my request in paper form (if applicable), a reasonable amount for supplies to provide the Requested Information in electronic form (if applicable) and the actual costs of postage if I request that the information be mailed to me. If I am granted access to the Requested Information, I (please check the appropriate boxes) ☐ would ☐ would not like Well Sense Health Plan to provide me with an additional explanation of such Requested Information at an additional cost to me of $0.

I hereby authorize Well Sense Health Plan to release to me the information requested above.

Signature of Member/Personal Representative Date

WELL SENSE HEALTH PLAN USE ONLY	
REQUEST RECEIVED BY:	DATE (MM/DD/YYYY)

Mail or Fax completed form to:

Well Sense Health Plan
ATTN: Member Services Dept.
1155 Elm Street, Suite 600
Manchester, NH 03101
Fax: 617-897-0884