Request for Access to Information Form

Please Note: This form is used to request a copy of your member information from WellSense 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 WellSense member ID card)

Member's last name

First name | Middle initial

Address | City | State | Zip code

Phone

Information being requested

Please describe the type of information you are requesting. **Please also check one of the three boxes below**:

☐ 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 WellSense Health Plan.

☐ I would prefer to receive the Requested Information in the form of a summary prepared by WellSense Health Plan at a cost to me of $0.

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 WellSense 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 WellSense Health Plan who did not participate in WellSense Health Plan's decision to deny my request.

I understand that WellSense 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:	☐ Electronically ☐ Paper copy
If you selected 'paper copy', how would you like it delivered?	☐ Pick-up or view the Requested Information at a mutually agreeable time and place ☐ Mail the Requested Information to me at the following address (if different than address above, write below). _____ _____ _____

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

Signature of Member/Personal Representative	Date

WELLSENSE HEALTH PLAN USE ONLY	
Request received by:	Date (mm/dd/yyyy)

Mail or fax completed form to:

WellSense Health Plan
Attn: Privacy Officer
529 Main Street, Suite 500
Charlestown, MA 02129

Fax: 617-897-0884