Indiana Health Coverage Programs

M B E R A C C O U N T I N G R E Q U E S T

Section A: IHCP Member requesting disclosure accounting

Name: _____

Address: _____

City, State, ZIP Code: _____ Phone Number: _____

IHCP RID Number: _____ Social Security Number: _____

Section B: To the member – Please read the following and complete the information requested.

You have the right to an accounting of the disclosures that the Indiana Health Coverage Programs (IHCP) or our business associates have made of your protected health information. The accounting period is the six years prior to your request, except you are not entitled to an accounting of disclosures made before April 14, 2003, which is the compliance date under the federal privacy rules. This list will not include disclosures we or our business associates made to provide treatment to you, to make or obtain payment for your health care services, for our health care operations, for national security, or for use by prisons or law enforcement officials. This list will also not include information released to you by the IHCP that you requested in writing, or information released to persons who are involved in your care.

You are entitled to one free disclosure accounting each 12 months. The IHCP may charge you for each additional disclosure accounting you request during the same 12-month period. If the IHCP is going to charge you, you will be notified of the charge, in writing, before the disclosure accounting is mailed to you.

Section C: To the member – Please sign the form and complete the appropriate information.

I request an accounting of the disclosures of my protected health information as described above, made by the Indiana Health Coverage Programs (IHCP), within the six years prior to the date of this request. This will not include disclosures made by the IHCP prior to April 14, 2003. I understand that I am entitled to one free disclosure accounting each 12 months.

Signature: _____ Date: _____

☐ I have already received a disclosure accounting from the IHCP within the previous 12 months. I have been notified that the IHCP is going to charge {$XX} and I agree to pay for this accounting disclosure.

Signature: _____ Date: _____

Section D: To the member's personal representative – Please sign the form and complete the appropriate information

If this request is from a personal representative on behalf of the IHCP member, please provide a copy of the documentation to support the representation and complete the following:

Personal Representative's Name: _____ Date: _____

Relationship to IHCP Member: _____

This form must be notarized if submitted by the member's personal representative.

Subscribed and sworn (affirmed) before me this _____ **day of** _____ **,** _____

Signature: _____

Notary Public in and for the state of _____

In the county of _____

(Affix seal)

My commission expires: _____

Please mail this completed form to the following address:
IHCP Privacy Office
P.O. Box 7260
Indianapolis, IN 46207-7260