UNIVERSITY OF MICHIGAN HEALTH PLAN
UNIVERSITY OF MICHIGAN HEALTH

Request for Protected Health Information Form

SECTION A: INFORMATION ABOUT YOU

Member's Name:			Member ID Number:
Address:			Gender: ☐ Male ☐ Female
City:	State:	Zip:	Date of birth:
Daytime phone number:		Evening phone number:	

SECTION B: INFORMATION REQUESTED
Address you would like requested information sent to, if different than above:

Address:		
City:	State:	Zip:

Information requested from records maintained by University of Michigan Health Plan (UM Health Plan):

- ○ Processed Claims: This is a summary of claims paid or denied. (Please note: This does not include information on claims received but not yet processed – if you would like the status of those claims, you may call Customer Services at the toll-free number on the back of your UM Health Plan ID card.)
- ○ Enrollment or eligibility information that UM Health Plan has received from the Subscriber's employer or from the Subscriber/Member.
- ○ Case Management and medical utilization management information.
- ○ Other information (please describe):

Type of information requested:

- ○ I request the information checked above for my UM Health Plan medical benefits.
- ○ I request the information checked above for my UM Health Plan pharmacy benefits.
- ○ I request the information checked above for my UM Health Plan behavioral health benefits.

You will be provided with information for a 24-month period unless otherwise specified. There may be other PHI created or maintained by the Subscriber's employer/Group Health Plan and/or its business associates and not included in this response.

SECTION C: SIGNATURE
Please fill out this form completely. UM Health Plan will not consider this a complete request if information is missing. You may not be entitled to receive all your PHI, and will not receive information such as psychotherapy notes or information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding.

Member signature	Date	Name and relationship of person completing this form, if not the member

Please return to:

University of Michigan Health Plan
PO Box 30377
Lansing, MI 48909-7877
Fax: 517-364-8411

For Health Plan Use Only		
Accepted ☐ Denied ☐	Date logged:	Reviewed by:
If denied, why:		
Sent to:		Date sent: