meridianhealth

1 Campus Martius, Suite 700
Detroit, MI 48226

888-437-0606
TTY: 711
www.mhplan.com

Dear Member,

Inside is an Accounting of Disclosed Protected Health Information Request (PHI) form. This form lets you obtain an accounting of your PHI disclosed by MeridianHealth (Meridian) to someone other than you. You or someone else has asked for this form on your behalf.

You are allowed one free accounting each year. Meridian may apply a reasonable, cost-based fee for additional requests within a year. If there is a fee, Meridian will give you an invoice so you can decide whether you want to change or cancel your request.

Below are steps for each section. You can use this as a checklist.

☐**SECTION 1: Your info**

☐**SECTION 2: Date range for the accounting**

☐**SECTION 3: How to obtain records**

☐**SECTION 4: Sign and date**

☐**SECTION 5: Return the form**

- All sections must be filled out or the form will not be processed
- This form does not take effect until Meridian receives it
- A response approving or denying your request will be sent to you within 30 days of us receiving this completed form

Please call Member Services at **888-437-0606** or email **privacy.mi@mhplan.com** if you have questions or need help filling out this form.

ACCOUNTING OF DISCLOSED PHI REQUEST FORM

This form allows you to request an accounting of certain disclosures of protected health info made by MeridianHealth (Meridian). You may request an accounting six years before to the date on which the accounting is requested. Meridian may charge a fee for this request.

SECTION 1: YOUR INFO

Name (First and Last):		**Date of Birth (MM/DD/YYYY):**	
Member ID#:		**Phone:**	
Address:	**City:**	**State:**	**Zip:**

SECTION 2: DATE RANGE FOR THE ACCOUNTING

FROM: (MM/DD/YYYY) _____

TO: (MM/DD/YYYY)

SECTION 3: HOW TO OBTAIN RECORDs (CHOOSE ONE)

☐**Fax to:** _____

☐**By email:** _____

☐**In person at a location decided by Meridian (must make an appointment)**

☐**Other electronic format (e.g. CD)** _____

☐**By mail to the following address:**

Address:_____ **City:** _____ **State:** _____ **Zip:** _____

SECTION 4: SIGN AND DATE

Who is signing? ☐ Member listed above ☐ Parent of minor member listed above ☐ Someone other than member*

Signature: _____ **Date:** _____

Name (printed): _____

***Description of authority to act on behalf of the member (e.g. guardianship, durable power of attorney, court order, parent of minor child, etc.):** _____

You must attach the legal records shown above that name you as the representative of this member. There will be delays in this request if you do not give us this info.

SECTION 5: RETURN THE FORM

Send us a copy of this form by choosing one of the following:

1. **Fax this form to 313-324-9075**
2. **Email this form to privacy.mi@mhplan.com**
3. **Send this form by mail to the address below:**

MeridianHealth
Attn: Privacy Officer
1 Campus Martius, Suite 700
Detroit, MI 48226

meridianhealth

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MeridianHealth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MeridianHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

MeridianHealth:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Meridian's Grievance Coordinator.

If you believe that MeridianHealth has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Meridian's Grievance Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Meridian's Grievance Coordinator is available to help you.

Mail:	MeridianHealth Attn: Grievance Coordinator P.O. Box 44287 Detroit, MI 48244
Telephone:	888-437-0606 (TTY users should call 711)
Fax:	313-463-5259
Email:	medicaidgrievances@mhplan.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-437-0606 (TTY: 711).

العربية (Arabic): ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 888-437-0606 (رقم هاتف الصم والبكم: 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 888-437-0606 (TTY: 711)。

Tagalog (Tagalog-Filipino): PAUNAWA: Kung nagsasalita kayo ng Tagalog, maaari kayong gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 888-437-0606 (TTY: 711).

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu quý vị nói Tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 888-437-0606 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 888-437-0606 (TTY: 711).

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 888-437-0606 (TTY: 711)로 전화해 주십시오.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 888-437-0606 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 888-437-0606 (TTY: 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 888-437-0606 (TTY: 711).

Shqip (Albanian): KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 888-437-0606 (TTY: 711).

বাংলা (Bengali): **লক্ষ্য করুন**: **যদি আপনি বাংলা ভাষায় কথা বলেন, তাহলে ভাষা সহায়তা পরিষেবা নিঃখরচায় উপলব্ধ আছে। ফোন করুন** 888-437-0606 (TTY: 711)।

日本語 **(Japanese)**: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。888-437-0606 (TTY: 711) まで、お電話にてご連絡ください。

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 888-437-0606 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ܣܘܪܝܬ (Assyrian):: ܙܘܗܪܐ: ܐܢ ܐܢܬܘܢ ܟܐ ܡܗܡܙܡܝܬܘܢ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬܘܢ ܕܦܠܚܝܬܘܢ ܡܢ ܚܠܡܬܐ ܕܗܝܪܬܐ ܕܠܫܢܐ ܡܓܢܢܐܝܬ. ܩܪܘܢ ܥܠ ܡܢܝܢܐ 888-437-0606 (TTY: 711)