meridiancomplete

MI HEALTH LINK
Linking Medicare and Medicaid for you

1 Campus Martius, Suite 700
Detroit, MI 48226

1-855-323-4578
TTY: 711
www.mhplan.com

Dear Member,

Inside is a form which lets you tell MeridianComplete (Medicare-Medicaid Plan) to stop sharing your Protected Health Info (PHI) with someone you authorized. You or someone else has asked for this form on your behalf. Below are steps for each section. You can use this as a checklist.

☐**SECTION 1: Your info**

☐**SECTION 2: Person or entity to remove authorization**

☐**SECTION 3: Sign and date**

☐**SECTION 4: Return the form**

- All sections must be filled out or the form will not be processed
- This form does not take effect until MeridianComplete receives it
- Info shared before Meridian receives this form cannot be taken back

Please call Member Services at **1-855-323-4578** (TTY users should call **711**) or email **memberservices.MI@mhplan.com** if you have questions or need help filling out this form. We are open **Monday – Sunday, 8 a.m. to 8 p.m.**

MeridianComplete is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees.

AUTHORIZATION REVOCATION FORM

This form lets you to tell MeridianComplete that you want to take away permission to release your PHI to a person or entity. Any info MeridianComplete shared prior to the date that MeridianComplete receives this form is not affected by this revocation.

SECTION 1: YOUR INFO		
Name:		**DOB:**
Member ID #:		**Phone:**
Address:	**City:**	**State/Zip:**

SECTION 2: PERSON OR ENTITY TO REVOKE AUTHORIZATION		
☐ **I revoke all authorizations with MeridianComplete to release my PHI to another person.**		
☐ **I revoke my authorization to the person(s) listed below (add more sheets if needed).**		
Name:		**Phone:**
Address:	**City:**	**State/Zip:**
Name:		**Phone:**
Address:	**City:**	**State/Zip:**

SECTION 3: SIGN AND DATE

Who is signing?

☐ **Member listed above** ☐ **Parent of minor member listed** ☐ **Someone other than member***

Signature: _____ **Date:** _____

Name (printed): _____

***Description of authority to act on behalf of the member* (e.g., 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 4: RETURN THE FORM

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

1. **Fax this form to 313-294-5573**
2. **Email this form to CELegalDocuments@mhplan.com**
3. **Send this form in the enclosed envelope to the address below. No stamp is needed.**

Meridian Health Plan
Attn: Privacy Officer
1 Campus Martius, Suite 700
Detroit, MI 48226

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MeridianComplete (Medicare-Medicaid Plan) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MeridianComplete does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

MeridianComplete:

- 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 MeridianComplete Member Services.

If you believe that MeridianComplete 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 MeridianComplete's Grievance Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, MeridianComplete's Grievance Coordinator is available to help you.

Mail:	MeridianComplete Attn: Medicare Grievance Coordinator P.O. Box 44260 Detroit, MI 48244	Telephone: Hours: Fax: Email:	1-855-323-4578 (TTY users should call 711) Monday – Sunday, 8 a.m. to 8 p.m. 1-313-294-5552 medicaregrievances@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

1-800-368-1019, 1-800-537-7697 (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 1-855-323-4578 (TTY: 711).

العربية (Arabic): ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-323-4578 (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1-855-323-4578 (TTY: 711)。

Tagalog (Tagalog-Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-323-4578 (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 1-855-323-4578 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-323-4578 (TTY: 711).

한국어 **(Korean):** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-323-4578 (TTY: 711)로 전화해 주십시오.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-323-4578 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-323-4578 (TTY: 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-855-323-4578 (TTY: 711).

Shqip (Albanian): KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 1-855-323-4578 (TTY: 711).

বাংলা (Bengali): লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-1-855-323-4578 （TTY: ১-711）।

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。1-855-323-4578 (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 1-855-323-4578 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ܐܬܘܪܝܐ (Assyrian): ܙܘܗܪܐ: ܐܢ ܐܢܬ ܟܐ ܗܡܙܡܬ ܠܫܢܐ ܐܬܘܪܝܐ، ܡܨܝܬ ܕܩܒܠܬ ܚܕܡܬܐ ܕܗܝܪܬܐ ܕܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܝ ܥܠ ܡܢܝܢܐ 1-855-323-4578 (TTY: 711)