1 Campus Martius, Suite 700
Detroit, MI 48226

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

Dear Member,

Inside is a Request for Restriction of Use of Protected Health Info (PHI) form. This form lets you ask that we restrict our sharing of your PHI for treatment, payment and health care operations to persons involved in your care or payment for that care. You or someone else asked for a copy of this form. We will only make special requests or those required by law.

If the request is approved, you can take away the restriction at any time by writing to us. We can also take away our approval to a restriction at any time, and we will tell you in writing. If we do, the removal of restriction only applies to PHI that we create or get after we gave you our written notice of removing the restriction.

☐**SECTION 1: Your info**

☐**SECTION 2: Reason for request**

☐**SECTION 3: Location of contact**

☐**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 Meridian receives it**
- **A response approving or denying your request will be sent to you within 30 days of us receiving this completed form**
- **We will either approve or deny your request. You may have a right to a review of our denial if your request is denied for a reason other than this form not being filled out. We will give you steps for this second review if needed**

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.

REQUEST FOR RESTRICTION OF USE OF PHI

This form allows you to ask that Meridian restricts our use and disclosure of your protected health information to persons or entities involved in your care, or who are involved in the payment for that care.

SECTION 1: YOUR INFO			
Name (First and Last):		**Date of Birth (MM/DD/YYYY):**	
Member ID#:		**Phone:**	
Address:	**City:**	**State:**	**Zip:**

SECTION 2: REASON FOR REQUEST

Please tell us the PHI you would like to be handled in a different way and what restrictions you would like us to apply?

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SECTION 3: LOCATION OF CONTACT (CHOOSE ALL THAT APPLY)

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 4: 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 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.

meridianhealth

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

(Arabic): . :
.)711 : (888-437-0606

繁體中文 (Chinese): 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).

Ti ng Vi t (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).

(Korean): : ,
. 888-437-0606 (TTY: 711) .

: 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).

(Bengali): ,
888-437-0606 (TTY: 711)

(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)

(Assyrian):
888-437-0606 (TTY: 711)