



Accounting Request Form

You have the right to receive an accounting of any disclosures made by The Ohio State University Health Plan Inc. of your health and medical information. The following information is required to process your request:

Member Information

Name _____ Date of Birth ____/____/____

Address _____

Phone _____ E-mail Address _____

OSU Employee/Subscriber Information

Name _____ Employee ID _____

Requestor Information (complete if you are not the member)

Name _____

Address _____

Relationship to Member _____ Phone _____

Organizations from which you wish to receive an accounting:

____ OSU Health Plan (Medical) ____ Vision Service Plan ____ OSU Health Plan (UFSAP/EAP)
____ Global Care ____ Flexible Spending Account ____ Delta Dental
____ Other (please specify) _____

Period of time for which you wish to see the disclosures made _____

We are not required by law to include any of the following disclosures of your health information in an accounting to you:

- Disclosures made pursuant to an authorization signed by you or your representative;
- Disclosures to carry out our own or other providers' or plans' treatment, payment and health care operations;
- Disclosures made to you or to your personal representative;
- Disclosures made to persons involved in your care and/or payment or notification of next-of kin or family members;
- Disclosures for national security or intelligence purposes;
- Disclosures to correctional institutions or law enforcement officials about inmates or others in custody; or
- Disclosures that occurred prior to April 14, 2003

Signature

Date

Please note that we will not process any requests that are not signed by you or your personal representative.

Return this form to the Compliance and Quality Improvement Manager, OSU Health Plan, Inc., 700 Ackerman Road, Suite 440, Columbus, Ohio 43202 or fax to (614) 292-2667.