MyCareOhio
Connecting Medicare + Medicaid

ECHS Category - PHIA

Request for an Accounting of Disclosures of Protected Health Information (PHI)

Protected Health Information (PHI) means information about your health.
This form must be completed and signed to process this request.

1. Who is the Medicaid Member?

First name		Last name	Middle initial
Member ID number	Birthdate *(MM/DD/YYYY)*	Phone number	
Street			
City, state, ZIP code			

2. Description of the Accounting Report

Once we get this signed request form, we will send you the Accounting Report.
The disclosures on the report are for reasons other than “treatment,” “payment,” or “health care operations.”

3. Accounting Report time period cannot be longer than six (6) years from the request date.

My request is for the dates below:

______________________ to ______________________
MM/DD/YYYY MM/DD/YYYY

4. Where do you want this Accounting Report to be sent?

Who is receiving this Accounting Report?
☐ Member ☐ Member’s Legal Representative ☐ Member’s Natural or Adoptive Parent

Print name of recipient
Recipient’s street address
City, state, ZIP code

Important Information:

- By signing this form, I allow **Aetna Better Health of Ohio (Medicare-Medicaid Plan)** to give an Accounting of Disclosures of PHI Report about the Member named in **Section 1** to the recipient named in **Section 4**.
- This approval is only for this request.
- Information in this report could be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws.
- Disclosures older than six years from when this request was made will not be included.

5. Signature of Member or Authorized Representative

Signature	Date
Print name	
If a legal representative signed this form, describe the relationship: (parent, legal guardian, Power of Attorney, personal representative)	

Authorized Representative means you have legal proof that you can act for this person.
A representative signs for a person who cannot legally sign on his or her own. If the member is less than 18 years old, a parent, or guardian should sign for the minor. If you are a representative signing this form you must send legal proof you can act for this person.

Do you have questions? We can help. **Call Aetna Better Health of Ohio (Medicare-Medicaid Plan) 1-855-364-0974 (TTY: 711),** 24 hours a day, 7 days a week

Please sign and return this completed form to: **Aetna HIPAA Member Rights Team**
PO Box 14079
Lexington, KY 40512-4079

Or you can fax it to: **1-859-280-1272**

Please allow 60 days for our response.

Aetna Better Health of Ohio is a health plan that contracts with both Medicare and Ohio Medicaid to provide benefits of both programs to enrollees