Vision Service Plan
3333 Quality Drive
Rancho Cordova, CA 95670

Request for Access to Protected Health Information

You have a right to access and inspect the personal information about you that Vision Service Plan (VSP), collects and maintains. HIPAA calls this your Protected Health Information (PHI) that is maintained in a Designated Record Set (DRS). This Designated Record Set includes enrollment information, claim requests for payment, claim payment, appeals and/or complaints files, and other records.

You can request information only about yourself, unless you are legally authorized to get information about another individual. In an effort to make this information more understandable to you, we can provide you with a report that summarizes your eligibility and claims history. If you request this eligibility and claims summary now, and later decide that you want supplemental information, you can request additional information at that time. If you need more detailed information now, you may request it.

When completing this form, please:
• Complete all sections entirely;
• Type or print information clearly;
• Provide us with your most current information.

Indicate the type of records you are requesting on the attached form, and the dates for which you want that information. We will respond to requests from a personal representative authorized by a Member to receive his or her Protected Health Information (e.g., parent, court appointed representative, family member). However, we may require additional documentation from the Member or the Member's personal representative to verify his or her authority to act on the Member's behalf. Please note that we will only supply you with Protected Health Information regarding vision care benefits
provided by VSP or its affiliates. To obtain your PHI concerning your medical, dental or any other covered entity benefit not provided by VSP or its affiliates, you must contact the entity that administers those benefits directly. If we are unable to send you a copy of your PHI within 30 days from the date we receive your request, you will be contacted and advised about the delay. If you have any questions about filling out this form, please call (800) 877-7195 to speak with a Customer Care Representative.

VISION SERVICE PLAN
Request for Access to Protected Health Information

Use this form to request access to your Protected Health Information from Vision Service Plan. Complete this form in its entirety to insure that your Protected Health Information can be located and released. Once the request is approved, a copy of your Protected Health Information will be mailed to you or your authorized personal representative. Please print or type.

Section 1: Protected Health Information Requested For:

_____
Name (First, Middle Initial, Last)

_____ _____
Address City, State ZIP

Phone: ( ) - Date of Birth : _____ ☐ Male ☐ Female

Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

If other, describe type of relationship _____

Section 2: Type(s) of Information Requested

Please choose one of the three options below to indicate what type(s) of information you would like to receive:
☐ **(**Option 1) I would like a report that summarizes my eligibility and claims information**.**
☐ (Option 2) I would like the following information (if applicable):
☐ Eligibility
☐ Claims payment/adjudication information
☐ Appeals/complaints I have filed
☐ (Option 3) I have previously requested a summary report of my eligibility and claims information and would like more detailed information about the following claims or eligibility periods:
Claim Date(s) of Service _____
Eligibility Period(s) _____
Information Requested (relating to these specific claims/authorizations):
☐ Detailed claims payment/adjudication information
☐ Appeals/complaints I have filed
☐ Other _____

Section 3: Date Range of Information Requested

I would like this information for the following dates:
☐ From ___/_____/_____ to ___/_____/_____
☐ All claims and eligibility information currently maintained by VSP.
An authorized signature of the individual, or authorized signature of the personal representative of the individual, who is requesting the Protected Health Information is required:

I authorize the release of my Protected Health Information to me at the address stated in Section 1 of this form. I understand that this request does not apply to certain health information, including information that is not received or maintained by Vision Service Plan, information compiled in reasonable anticipation of or for litigation and any information not available for access under HIPAA.

_____ _____
Signature of Individual Date

_____ _____
Signature of Personal Representative Date

Personal Representative's Name

Address | City, State, ZIP

( ) -
Phone

Relationship to individual and authority to act for individual

Important: A personal representative, including a parent, legal guardian, or executor of an estate, may be required to supply a copy of legal documentation. If you have questions, please (800) 877-7195 to speak with a Customer Care Representative who can answer your questions about legal documentation.

Section 4: Subscriber Information

Subscriber Name | Employer

Subscriber Identification Number | Group Number

Address | City, State ZIP

( ) -
Phone

Please return the completed form to:

Vision Service Plan
3333 Quality Drive (MS163)
Rancho Cordova, CA 95670