MASSACHUSETTS

REQUEST FOR AN ACCOUNTING OF DISCLOSURES

Please retain a copy of this form for your records and mail or fax completed form to:
Blue Cross Blue Shield of Massachusetts, Inc.
101 Huntington Avenue – Suite 1300
Boston, MA 02199-7611
Attention: Law Department – Mailstop 01/18
Privacy Program Manager
Fax: (617) 246-3550

Member's name: _____ Date of birth: _____

Member's ID#: _____ Date of request: _____

Address: _____

Phone number: _____

Blue Cross and Blue Shield of Massachusetts (Blue Cross) will provide an accounting of certain disclosures of your protected health information. Your accounting will not include, for example, disclosures Blue Cross made for purposes of treatment, payment, or health care operations. Nor will your accounting include disclosures that took place more than six years ago. Blue Cross reserves the right to charge a fee if you request more than one disclosure accounting within a twelve-month period.

I'm requesting an accounting of disclosures for the following time frame *(e.g. from 01/09/2017 to 01/30/2017)*

From: _____ To: _____

If you are only seeking an accounting of certain type(s) of disclosures, or disclosures to a specific person, please describe the disclosures for which you are seeking an accounting:

_____

_____

_____

I understand the accounting will be provided to me within 60 days of the date of receipt of this request, unless Blue Cross extends the time frame for an additional 30 days and provides me with a written statement of the reason(s) for the delay and the date by which I can expect to receive the accounting. Blue Cross will send this accounting to the current address Blue Cross has for me in its records. If the information on this form is not complete, Blue Cross will return the form to you, and this request will not be considered until Blue Cross has received complete information.

The member named above should be the person signing this request form. If the member is a minor, a parent or legal guardian must sign. If this form is completed by a Legal Representative, other than a parent (i.e., a person who has legal authority to act on the member's behalf), please ensure you have completed and submitted the Blue Cross Documentation of Legal Representative Status Form prior to submitting this form to Blue Cross.

Member: _____ Date: _____

Or Legal representative: _____ Date: _____

Relationship: _____

Questions regarding this form should be directed the Privacy Program Manager at (617) 246-3500

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711).

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).

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