



Request to Access Protected Health Information (PHI)

Use this form to request access to your Protected Health Information (PHI). By law an individual has the right to inspect and obtain a copy of his or her PHI in the Designated Records Set(s) that Blue Cross and Blue Shield of Illinois or its Business Associates maintain. **If you need assistance in completing this form, please call the Customer Service number listed on the back of your Insurance Identification Card.**

This form must be completed entirely. When complete send to:

**Blue Cross and Blue Shield of Illinois
P.O. Box 805106
Chicago, IL 60680-4112**

Section A: The individual for whom access is being requested. Please complete the following:					
Name _____		Group # _____		Identification\Subscriber # _____	
Social Security Number _____		Date of Birth _____			
Address _____			City _____		State _____ ZIP _____
Area Code & Telephone Number _____			E-mail address (if available) _____		Country _____

Section B: Please place an "X" in the box next to the records you wish to inspect or obtain a copy of and indicate "From" and "To" dates:					
Enrollment Records	From:	To:	Claim Records	From:	To:
<input type="checkbox"/> Application/Underwriting/Attending Physician Statement Record	_____	_____	<input type="checkbox"/> Medical	_____	_____
<input type="checkbox"/> Premium Payment/Billing History	_____	_____	<input type="checkbox"/> Dental	_____	_____
			<input type="checkbox"/> Prescription Drugs	_____	_____
			<input type="checkbox"/> Vision	_____	_____
			<input type="checkbox"/> Mental Health	_____	_____

Section C: By placing an "X" in the appropriate box, please indicate the manner in which you wish to receive/review your information. Select only one option:
<input type="checkbox"/> Paper copy of information via US Mail
<input type="checkbox"/> Send me an electronic copy, if available. Note: You must provide an email address
<input type="checkbox"/> Allow me to view my records in person. I understand that I will be contacted to arrange for this

Section D: Signature.	
Signature of Individual or Individual's Personal Representative _____	Date: month/day/year _____

Section E: If Section D is signed by a Personal Representative, please complete the information below:					
Personal Representative's Name _____			Relationship to Individual _____		
Personal Representative's Address _____		City _____		State _____	ZIP _____
Personal Representative's Area Code & Telephone Number _____		Personal Representative's E-mail address (if available) _____		Country _____	