AETNA BETTER HEALTH® OF OHIO

Privacy Request Form

Date of Request: _____

To request member information from Aetna Better Health of Ohio, please check one or more of the boxes below.

- ☐ Receive copy of privacy practices.
- ☐ Receive claim records.
- ☐ Change something in member records.
- ☐ Receive list of organizations to whom Aetna Better Health gives out member records.
- ☐ Limit how Aetna Better Health uses and gives out member records.

Member Name_____ Date of Birth: _____ID #: _____

Phone: (_____)_____

Are you the member? ☐ Yes ☐ No **If "NO", tell us who you are by checking one of the boxes below. Please give Aetna Better Health copies of papers that show you have the right to make this request.**

- ☐ I am the member's guardian or parent.
- ☐ I make health care decisions for the member.
- ☐ The member has died, and I take care of his or her estate.
- ☐ Other (explain) _____

Name of Requestor (if not member): _____

Please Explain Your Request

Please tell us what you want to receive and why. You need to provide dates of service, names of providers, etc. Aetna Better Health Plan of Ohio may charge you to receive copies of member records

or a list of people and companies to which we give out member records. You need to tell us if you cannot pay any fee.

_____
_____
_____
_____
_____
_____
_____

Where Do You Want the Records Sent

Address: _____

Street City, State Zip

I (the member or person acting for the member) agree to the following:

- I may authorize Aetna Better Health of Ohio to use or give out member records. When I give an approval, Aetna Better Health will give out member records to a person or company.
- I know that member records can't always be kept safe under privacy laws. I know a person or company that receives member records can give them out again.
- I may take back this authorization by submitting to Aetna Better Health of Ohio a request in writing.
- I may not be allowed to take back an authorization in some cases. I can learn more about this in the Aetna Better Health of Ohio's Notice of Privacy Practices.
- This authorization will end in twelve (12) months from the date of signature.
- If I want this authorization to end before this date, I will tell the Plan when and the reason I want it to end. Use the space below to explain:

_____
_____
_____
_____

- I have read and understand this form.
- I am entitled to receive a copy of this form.

_____ _____

If member - Signature of Member Date

_____

If member -Print Member Name

Please send this Privacy Request Form to:

Aetna Better Health of Ohio
Privacy Officer or Coordinator
7400 West Campus Road
New Albany, OH 43054

Call Aetna Better Health of Ohio at **1-855-364-0974** (TTY: 711) with questions or comments.

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

You can get this information for free in other languages. Call 1-855-364-0974, TTY 711, 24 hours a day, 7 days a week. The call is free.

Puede obtener esta información en otros idiomas de manera gratuita. Llame al 1-855-364-0974 y TTY al 711, 24 horas al día, siete días de la semana. Esta llamada es gratuita.