AmeriHealth Caritas VIP Care

Request for List of Disclosures of Protected Health Information

Use this form to request an Accounting of Disclosures of your protected health information (PHI).

Section A: Requesting individual
Please complete the following:

Name:		Phone:
Address:		City:
State:	ZIP code:	Member ID number:

Please read and complete the following:
You have the right to an Accounting of Disclosures that we, or our business associates, have made of your PHI in the six years prior to the date of your request. However, we are not required to account for disclosures that were:

- Made to carry out treatment, payment or operations.
- To the patient or the patient's personal representative.
- Incidental disclosures made in connection with a use or disclosure otherwise permitted or required by HIPAA.
- Made to persons involved in a patient's care or as part of an inpatient directory.
- Pursuant to an authorization for release of information signed by the patient or patient's personal representative.
- For national security or intelligence purposes.
- To correctional institutions or law enforcement officials under certain circumstances.
- Part of a limited data set, when the recipient has executed a data use agreement, disclosed for research, public health or certain health care operations purposes.
- Made prior to April 14, 2003.

Section B: Dates of disclosures
Please specify the date range for the Accounting of Disclosures you are requesting:

Start:	End:

You are entitled to one free disclosure accounting every 12 months upon request. We reserve the right to charge you a reasonable fee for each additional disclosure accounting you request during the same 12-month period.

Section C: Signature

I request an Accounting of all Disclosures of my PHI as specified above. I understand that I am entitled to one free disclosure accounting every 12 months. I agree to pay a reasonable fee for this accounting if I have already received one within the previous 12 months.

Signature:	Date:

Section D: Personal representative
If you are not the member, please sign and date Section D of this form. Check the box that describes your relationship to the member. **If you are not a parent or legal guardian of the member, please attach proof of your relationship to the member (e.g., power of attorney, personal representative, etc.).**

Print name of personal representative:	
Signature of personal representative:	Date:

☐ Parent or legal guardian ☐ Power of attorney ☐ Executor ☐ Other:________________________

Please return this form to: AmeriHealth Caritas VIP Care
Medicare Compliance
3875 West Chester Pike
Newtown Square, PA 19073

AmeriHealth Caritas VIP Care

Discrimination is Against the Law

AmeriHealth Caritas VIP Care (HMO-SNP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. AmeriHealth Caritas VIP Care does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

AmeriHealth Caritas VIP Care:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you need these services, contact AmeriHealth Caritas VIP Care Member Services at **1-833-535-3767** (**TDD 711**). We are available from 8 a.m. – 8 p.m., five days a week, April 1 – September 30, and from 8 a.m. – 8 p.m., seven days a week, October 1 – March 31.

If you believe that AmeriHealth Caritas VIP Care has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

- AmeriHealth Caritas VIP Care Grievances and Complaints Department, P.O. Box 7140, London, KY 40742- 7140, Phone: 1-833-535-3767 (TDD/TT: 711), Fax: 1-855-221-0046.
- You can file a grievance by mail, fax, or phone. If you need help filing a complaint or grievance, AmeriHealth Caritas VIP Care Member Services is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

AmeriHealth Caritas VIP Care is a HMO-SNP plan with a Medicare contract and a contract with the Florida Medicaid program. Enrollment in AmeriHealth Caritas VIP Care depends on contract renewal. This plan is available to anyone who has both Medical Assistance from the State and Medicare

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Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-833-535-3767. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-833-535-3767. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-833-535-3767。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-833-535-3767。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-833-535-3767. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-833-535-3767. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-833-535-3767 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

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German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-833-535-3767. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-833-535-3767 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону1-833-535-3767. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-833-535-3767 . سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-833-535-3767 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-833-535-3767. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-833-535-3767. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan1-833-535-3767. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

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Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-833-535-3767. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-833-535-3767 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサー ビスです。

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