

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

File Number: _____

You have the right to request to inspect your protected health information in records, which Medi-Cal creates or maintains. You also have the right to request copies of those records. You will be charged for the cost of copying and postage, fees are indicated below. You will receive a response to your request within 30 days after we receive your request and payment. If you want copies of your records mailed, you need to send us a photocopy of your California driver's license, Department of Motor Vehicles Identification Card, or other valid identification. You will also need to send documentation verifying your address. Checks should be made payable to the Department of Health Services (**DHS**). Mail this completed form to:

Department of Health Services
EDS Communications
P. O. Box 526018
Sacramento, CA 95852-6018
(916) 636-1980

INDIVIDUAL INFORMATION			
LAST NAME		FIRST NAME	MIDDLE INITIAL
ADDRESS		CITY/STATE	ZIP CODE
BENEFICIARY ID NUMBER		DATE OF BIRTH	
DAYTIME TELEPHONE NUMBER () -	EVENING TELEPHONE NUMBER () -	EMAIL ADDRESS	BEST HOURS TO REACH YOU
PROTECTED HEALTH INFORMATION YOU WANT TO ACCESS			
WHAT TYPE OF PROTECTED HEALTH INFORMATION DO YOU WANT TO ACCESS?			
<input type="checkbox"/> CLAIM DETAIL REPORTS, which show claims paid by Medi-Cal for services received. (\$25 fee)		<input type="checkbox"/> CASE MANAGEMENT RECORDS, which show case manager notes (\$15 fee)	
<input type="checkbox"/> TREATMENT AUTHORIZATION REQUEST SCREENS. Printouts show which providers have requested services including the type and quantity, whether services were approved, denied, modified, or deferred, including a simple description of the decision, and whether the provider has billed for these services. (\$15 fee)		<input type="checkbox"/> OTHER _____	
		<input type="checkbox"/> OTHER _____	

FOR WHAT TIME PERIOD DO YOU WANT INFORMATION?	
FROM DATE	TO DATE
METHOD TO ACCESS YOUR PROTECTED HEALTH INFORMATION	
<input type="checkbox"/> PLEASE MAIL ME A COPY OF THE REQUESTED INFORMATION. <input type="checkbox"/> I WISH TO REVIEW THE REQUESTED INFORMATION IN PERSON. <input type="checkbox"/> I REQUEST THAT A PERSON OF MY CHOOSING BE ALLOWED TO INSPECT MY RECORDS.	
NAME	Appleby & Company, Inc.
TELEPHONE NUMBER	559-222-8402
ADDRESS	2828 N. Wishon Ave., Fresno, CA 93704
RELATIONSHIP TO YOU	
IF YOU REQUEST TO REVIEW RECORDS IN PERSON YOU WILL BE CONTACTED TO SCHEDULE AN APPOINTMENT.	
LOCATION AVAILABLE FOR IN PERSON REVIEW SACRAMENTO ONLY	
IDENTIFICATION INFORMATION	
<input type="checkbox"/> COPY OF IDENTIFICATION ATTACHED TYPE _____ (CA DRIVER'S LICENSE, CA DMV IDENTIFICATION CARD, BIRTH CERTIFICATE, BENEFICIARY IDENTIFICATION CARD, MANAGED CARE CARD, STATE OR FEDERAL EMPLOYEE ID CARD) NUMBER _____	
I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT	
BENEFICIARY SIGNATURE	DATE

(IF NO IDENTIFICATION IS ATTACHED YOUR SIGNATURE MUST BE NOTARIZED.)

NOTARIZED BY _____ ON _____(DATE)

NOTARY PUBLIC NUMBER _____

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC

ADDRESS VERIFICATION ATTACHED

FORM OF ADDRESS VERIFICATION _____ (UTILITY BILL,
PHONE BILL, DRIVER'S LICENSE, ETC.)

**NOTE: ANY ATTEMPT TO FALSELY GAIN ACCESS TO PROTECTED HEALTH
INFORMATION IS SUBJECT TO LEGAL PENALTIES.**