Wellpoint

Request for Protected Health Information Records (PHI)

For Wellpoint plan members

PART A: Whose records do you want?

Last name		First name	MI
Mailing address		City	State / ZIP code
Date of birth (MM/DD/YYYY)	Sex ☐ Male ☐ Female	Relationship to enrollee ☐ Self ☐ Spouse ☐ Child ☐ Other (explain)	
Plan ID number		Last name of Wellpoint enrollee (if not this member)	
Plan group number		First name of Wellpoint enrollee (if not this member)	MI

PART B: Which records are you requesting?

What are the dates of the records you're requesting? From: To:

Would a summary of the records be okay? ☐ Yes ☐ No

Which records do you want to review? (check all that apply)

☐ Explanation of Benefits (EOBs) ☐ Medical records ☐ Billing records ☐ Other records (describe below)

PART C: How do you want to get these records?

How would you like to access these records? (check only one box) ☐ Inspect ☐ Copy

If you want copies, you may be charged 20 cents per page. Are you willing to pay this cost? ☐ Yes ☐ No

How would you like these records to be delivered?

☐ U.S. Mail (address): _____

☐ Encrypted email (email address): _____

☐ Fax (number and name of recipient): _____

☐ Other (explain): _____

PART D: Your authorization

Signature of member or member's representative X	Date
Printed name of member or member's representative	Relationship to member or authority to act (if applicable)

To return the completed form by mail:

Wellpoint
P.O. Box 4095
Woburn, MA 01888

You can also send in the completed form from your Wellpoint member account or fax it to 978-474-5162.