

Request for an Accounting of Disclosures of Protected Health Information (PHI)

Protected Health Information (PHI) means information about your health. This form must be completed and signed to process this request.

First name	Las	Last name		
Member ID number	Birth date (MM/L	D/YYYY)	Phone number	
Street				
City, state, ZIP code				
2. Description of the Acc	ounting Report			
Once we get this signed re	quest form, we will send	I you the Acc	ounting Report.	
The disclosures on the rep	ort are for reasons other	than "treatm	ent," "payment," or "h	nealth care
operations."				
3. Accounting Report time		ger than six	(6) years from the re	equest date.
•			(6) years from the re	equest date.
3. Accounting Report time	below:	ger than six	(6) years from the re	
3. Accounting Report time My request is for the dates MM/DD/Y	below:	to		
3. Accounting Report time My request is for the dates MM/DD/Y	below: YYY s Accounting Report t	to		
3. Accounting Report time My request is for the dates MM/DD/Y 4. Where do you want thi Who is receiving this Accounting Report time MM/DD/Y	below: YYY s Accounting Report t	to o be sent?		/YYYY
3. Accounting Report time My request is for the dates MM/DD/Y 4. Where do you want thi Who is receiving this Accounting Report time MM/DD/Y	below: YYY s Accounting Report to unting Report?	to o be sent?	MM/DD	/YYYY
3. Accounting Report time My request is for the dates MM/DD/Y 4. Where do you want thi Who is receiving this Accounting Member Member	below: YYY s Accounting Report to unting Report?	to o be sent?	MM/DD	/YYYY

Important Information:

- By signing this form, I allow Aetna Better Health of Oklahoma to give an Accounting of Disclosures of PHI Report about the Member named in **Section 1** to the recipient named in **Section 4**.
- This approval is only for this request.
- Information in this report could be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws.
- Disclosures older than six years from when this request was made will not be included.

5. Signature of Member or Authorized Representative

Signature		Date
Print name		
If a legal representative signed this form, describe Attorney, personal representative)	be the relationship: (parent, legal	guardian, Power of

Authorized Representative means you have legal proof that you can act for this person. A representative signs for a person who cannot legally sign on his or her own. If the member is less than 18 years old, a parent, or guardian should sign for the minor. If you are a representative signing this form, you must send legal proof you can act for this person.

Do you have questions? We can help. Call Aetna Better Health of Oklahoma at: 1-844-365-4385.

Please sign and return this completed form to: Aetna HIPAA Member Rights Team

PO Box 14079

Lexington, KY 40512-4079

Or you can fax it to: 859-280-1272

Please allow 60 days for our response.



Aetna Better Health® of Oklahoma

Nondiscrimination Notice

Aetna complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Aetna does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

Aetna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - o Qualified sign language interpreters
 - o 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:
 - o Qualified interpreters
 - o Information written in other languages

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card or **1-800-385-4104**.

If you believe that Aetna 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 our Civil Rights Coordinator at:

Address: Attn: Civil Rights Coordinator

4750 S. 44th Place, Suite 150 Phoenix, AZ 85040-4015

Telephone: **1-888-234-7358 (TTY 711)**

Email: MedicaidCRCoordinator@aetna.com

You can file a grievance in person or by mail or email. If you need help filing a grievance, our Civil Rights Coordinator 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, 1-800-537-7697 (TDD).

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

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, and its affiliates.

Multi-language Interpreter Services

ENGLISH: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1844-365-4385** (TTY: **711**).

SPANISH: ESPAÑOL: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1 844-365-4385** (TTY: **711**).

VIETNAMESE: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Goi số **1 844-365-4385** (TTY: **711**).

TRADITIONAL CHINESE: 注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 **1844-365-4385** (TTY: **711**)。

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1844-365-4385 (TTY: 711).

GERMAN: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1 844-365-4385** (TTY: **711**).

:Arabic ملاحظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (TTY: 711) 844-365-4385.

HMONG: LUS CEEV: Yog tias koj hais Lus Hmoob, ces yuav muaj kev pab txhais lus pub dawb rau koj. Hu rau **1 844-365-4385** (TTY: **711**).

TAGALOG: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1 844-365-4385** (TTY: **711**).

FRENCH: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1 844-365-4385** (TTY: **711**).

LAO: ໂປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ຈະມີການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າໃຫ້ແກ່ທ່ານ. ໂທຫາເບີ 1 844-365-4385 (TTY: 711).

THAI: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1 844-365-4385 (TTY: 711).

CHEROKEE: %54ൽL: TGZ CWY SUhAൽJ AUhൽY, SUhAൽJ TGʻOLԾ՜ՈJ OʻOLൽSՐJ TGʻOLWՈJ, D4ൽT Ը AГൽJ dEGGJ ർY, hA OT RCԾʻOTൽLՈԴТ. ᲔԽABLЬ **1 844-365-4385** (TTY: **711**).

: Farsi توجه : اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با شماره (TTY: **711)**

Urdu: خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں **Urdu:** 1 **844-365-4385** (TTY: **711**)

BURMESE: မြန်မာ - သတိ - သင်မြန်မာစကားပြောဆိုပါက သင့်ထံ ဘာသာစကား ကူညီပံ့ပိုးရေး ဝန်ဆောင်မှုများကို အခမဲ့ ပေးဆောင်သွားပါမည်။ သင့်အိုင်ဒီကတ်၏ကျောဘက်ရှိ နံပါတ် သို့မဟုတ် 1 844-365-4385 (TTY: 711) သို့ ခေါ်ဆိုပါ။

1. Who is the Medicaid Memb	ber?			Readability Statistics	? ×
First name	Last name		Middle initial	Counts	
				Words	27
				Characters	125
Member ID number	Birth date (MM/DD/YYYY)	Phone number		Paragraphs	9
				Sentences	1
				Averages	
Street		<u>'</u>		Sentences per Paragraph	1.0
Sileet				Words per Sentence	6.0
				Characters per Word	4.0
011 1 1 7ID 1				Readability	
City, state, ZIP code				Flesch Reading Ease	59.7
				Flesch-Kincaid Grade Level	6.4
				Passive Sentences	0.0%
					ОК