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RECORDS REQUEST FORM

SECTION 1: YOUR INFO			
Name (First and Last):		**Date of Birth (MM/DD/YYYY):**	
Member ID#:		**Phone Number:**	
Address:	**City:**	**State:**	**Zip:**

SECTION 2: INFO YOU ARE REQUESTING

Tell us what info you need: _____

_____

Date range for the info you are asking for: _____ _____

From: (mm/dd/yyyy) To: (mm/dd/yyyy)

SECTION 3: REQUEST REASON (CHOOSE ONE)

☐**To help with my health care**	☐**For my own records**	☐**For a lawsuit, legal action, court case, settlement, etc.**

Other:

SECTION 4: WHERE TO SEND YOUR PHI (CHOOSE ONE)

Who should Meridian send this to (PLEASE PRINT NAME): _____

How should it be sent (CHOOSE ONE):

☐**Fax to:** _____

☐**By email:** _____

☐**In person at a location decided by Meridian (must make an appointment)**

☐**Other electronic format (e.g. CD)** ☐**By mail to the following address:**

Address:	**City:**	**State:**	**Zip:**

SECTION 5: SIGN AND DATE

Who is signing? ☐ **Member listed above** ☐ **Parent of minor member listed above** ☐ **Someone other than member***

Signature: _____ **Date:** _____

Name (printed): _____

***Description of authority to act on behalf of the member (e.g., durable power of attorney, court order, parent of minor child, etc.):** _____

You must attach the legal records shown above that name you as the representative of this member. There will be delays in this request if you do not give us this info.

SECTION 6: RETURN THE FORM

Send us a copy of this form by choosing one of the following:

1. **Fax this form to 313-324-9075**
2. **Email this form to privacy.il@mhplan.com**
3. **Send this form by mail to the address below:**

Meridian Medicaid Plan
ATTN: Compliance Department
1333 Burr Ridge Parkway Ste 100
Burr Ridge, IL 60527

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

Meridian:
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 Meridian's Grievance Coordinator.

If you believe that Meridian 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 Meridian's Grievance Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Meridian's Grievance Coordinator is available to help you.

Mail:
Meridian
Attn: Grievance Coordinator
PO Box 10353
Van Nuys CA 90410-0353

Telephone: 866-606-3700
(TTY users should call 711)

Fax: 833-669-1734

Email:
medicaidgrievances@mhplan.com

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 ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

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

Complaint forms are available at www.hhs.gov/ocr/complaints/index.html.

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Español (Spanish): ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 866-606-3700 (TTY: 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 866-606-3700 (TTY: 711).

繁體中文 (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 866-606-3700 (TTY: 711).

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 866-606-3700 (TTY: 711)번으로 전화해 주십시오.

Tagalog (Tagalog-Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 866-606-3700 (TTY: 711).

العربية (Arabic): ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 866-606-3700 (رقم هاتف الصم والبكم: 711).

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 866-606-3700 (телетайп: 711).

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 866-606-3700 (TTY: 711).

اُردُو (Urdu): خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں 866-606-3700 (TTY: 711).

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 866-606-3700 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 866-606-3700 (TTY: 711).

हिंदी (Hindi): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 866-606-3700 (TTY: 711) पर कॉल करें।

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 866-606-3700 (ATS : 711).

Ελληνικά (Greek): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 866-606-3700 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 866-606-3700 (TTY: 711).