

## Dear Member,

Inside is a Request for Restriction of Use of Protected Health Info (PHI) form. This form lets you ask that we restrict our sharing of your PHI for treatment, payment and health care operations to persons involved in your care or payment for that care. You or someone else asked for a copy of this form. We will only make special requests or those required by law.

If the request is approved, you can take away the restriction at any time by writing to us. We can also take away our approval to a restriction at any time, and we will tell you in writing. If we do, the removal of restriction only applies to PHI that we create or get after we gave you our written notice of removing the restriction.

SECTION 3: Location of contact

☐ **SECTION 2:** Reason for request ☐ **SECTION 4:** Return the form

✓ All sections must be filled out or the form will not be processed

✓ This form does not take effect until Meridian receives it

✓ A response approving or denying your request will be sent to you within 30 days of us receiving this completed form

We will either approve or deny your request. You may have a right to a review of our denial if your request is denied for a reason other than this form not being filled out. We will give you steps for this second review if needed

Please call Member Services at **888-437-0606** or email **privacy.mi@mhplan.com** if you have questions or need help filling out this form.

www.mimeridian.com

1-888-437-0606 (TTY: 711)

## **Request For Restriction of Use of PHI**

This form allows you to ask that Meridian restricts our use and disclosure of your protected health information to persons or entities involved in your care, or who are involved in the payment for that care.

	SECT	ION 1: YOUR INFO			
Name (First and Last):		Date of Birth (r	Date of Birth (mm/dd/yyyy):		
Member ID#:		Phone:			
Address:	City:	State:	Zip:		
	SECTION 2:	REASON FOR REQUEST			
Please tell us the PHI you wo	uld like to be handled in	n a different way and what	restrictions you would like us to appl		
SECT	ION 3: LOCATION OF	CONTACT (CHOOSE AL	L THAT APPLY)		
Who is signing?					
☐ Member listed above ☐	Parent of minor men	nber listed above 🔲 Son	neone other than member*		
Signature:			Date:		
Name (printed):					
*Description of authority to order, parent of minor child			, durable power of attorney, court		
You must attach the legal redelays in this request if you			entative of this member. There will b		
	SECTION	4: RETURN THE FORM			
Send us a copy of this form	by choosing one of the	following:			
Fax this form to 313-29	4-5573				
Email this form to <b>priv</b>	acy.mi@mhplan.com	n			
Send this form by mail	:	Meridian Attn: Privacy Officer 1 Campus Martius, Suit Detroit, MI 48226	e 700		