

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 1: Your info

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 1-888-437-0606 (TTY: 711)
or email privacy.mi@mhplan.com if you have
questions or need help filling out this form.**

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.

SECTION 1: YOUR INFO

Name (First and Last): _____ Date of Birth (mm/dd/yyyy): _____

Member ID#: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

SECTION 2: REASON FOR REQUEST

Please tell us the PHI you would like to be handled in a different way and what restrictions you would like us to apply:

SECTION 3: LOCATION OF CONTACT (CHOOSE ALL THAT APPLY)

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. guardianship, 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 4: RETURN THE FORM

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



Fax this form to **1-833-560-2912**



Email this form to **privacy.mi@mhplan.com**



Send this form by mail to the address below:

Meridian

Attn: Privacy Official

777 Woodward Ave, Suite 700

Detroit, MI 48226

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