



Horizon Blue Cross Blue Shield of New Jersey

## Request for Access to Private Information Form

**Instructions:** To request access to your private information (PI) held by Horizon Blue Cross Blue Shield of New Jersey and its business associates, please complete the information below, sign in the space provided and return to: **Horizon Blue Cross Blue Shield of New Jersey, Centralized Correspondence Unit, P.O. Box 1458, Newark, New Jersey 07101-1458.** (Only one form per member).

**Member Information (please print)**

Name: \_\_\_\_\_

Policy Identification #: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone #: \_\_\_\_\_

I hereby request, in accordance with my privacy rights, to inspect and/or copy private information contained in my Horizon BCBSNJ records as listed below.

Please specify the information requested: \_\_\_\_\_

or select from the list below:

**MEDICAL**

**DENTAL**

Enrollment Records

Enrollment Records

Claims Payment Records

Claims Payment Records

Case Management Records

Case Management Records

Utilization Management Records

Utilization Management Records

(e.g. Authorization Request Records, Appeals Request Records)

(e.g. Authorization Request Records, Appeals Request Records)

For what dates of service are you seeking these records? From: \_\_\_\_/\_\_\_\_/\_\_\_\_ To: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Unless otherwise specified, these records will be mailed via US Mail to the member address.**

I request that the records be mailed to me at a different address:

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

\*Signature of Requestor: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name: \_\_\_\_\_

***\*If you are not the member or his/her personal representative, you must submit legal documentation showing that you have the authority to make this request. (e.g., Power of attorney documents).***