**Instructions**:

Use this form to request certain records that we maintain containing your personal information. In some cases, we may not be able to honor your request. For example, federal law may prohibit such inspection.

You do **not** need to fill out this form to receive the things listed below. Instead, call Customer Service for:

* a copy of an Explanation of Benefits (EOB)
* information on a specific claim
* a summary of your claims that have been paid
* a copy of your application with us
* certification of your health coverage

Please complete this form and mail it to the address shown. If you have questions on how to use this form, contact Customer Service.

For details on your rights regarding your personal information that we maintain, see our Notice of Privacy Practices. You can find it on the Federal Employee Program Service Benefit Plan web site, **www.fepblue.org**, or call Customer Service at the number on the back of your ID card for a paper copy.

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| **MEMBER / REQUESTOR INFORMATION** | | | | | |
| Please provide the following details for the individual whose records you are requesting to be inspected. **Please print clearly**. | | | | | |
| IDENTITY OF MEMBER | | | | | |
| Member Name (First, MI, Last) | | | Date of Birth (mm/dd/yyyy) | | |
| Subscriber Name | | | Subscriber ID Number  **R** | | |
| IDENTITY OF REQUESTOR (if other than member). Must be the member’s parent, legal guardian or holder of power of attorney.  (If legal guardian or holder of a power of attorney, please attach legal documentation.) | | | | | |
| Requestor Name (First, MI, Last) | | | Relationship to Member | | |
| **MAILING ADDRESS** | | | | | |
| Copies of records and other correspondence about this request should be mailed to the address listed below and addressed to the:   Member  Parent, legal guardian or holder of power of attorney | | | | | |
| Street Address | | City | | State | ZIP |
| Daytime Phone Number  (     ) | You may be charged a reasonable fee to cover administrative and photocopying costs related to this request. You will be notified of any such charges and these must be paid prior to our mailing of the requested records to you. | | | | |
| **TYPE OF INFORMATION REQUESTED** | | | | | |
| Please identify the type of information you are requesting in the fields below. | | | | | |
| Date(s) of service / time frame | | | | | |
| Provider name(s) | | | | | |
| Diagnosis/es | | | | | |
| Procedure(s) performed | | | | | |
| General description of the information | | | | | |
| **SIGNATURE** | | | | | |
| Signature of Requestor  **X** | | | Date (mm/dd/yyyy) | | |
| Print Name | | | | | |

*When completed, send this form to:* **Federal Employee Program** • **P.O. Box 91058** • **Seattle, WA 98111-0158**

**Please keep a copy of this release for your records.**

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| *Please note:* | This request for inspection will be processed within 30 calendar days of receipt unless we notify you otherwise in writing. |

