

Request for Personal Information Form

To obtain copies of any personal information ConnectiCare may have on file regarding you, please provide the information requested below and return completed form to ConnectiCare, 175 Scott Swamp Road, Farmington CT, 06032-3124. Your copies will be mailed or available for pick-up within thirty (30) days after ConnectiCare's receipt of this completed form. If you are requesting information on behalf of someone other than yourself or your minor child, please contact Member Services at 1 800 251-7722 to obtain an authorization form.

Name: _____

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

Date of Birth: _____ Social Security Number: _____

ConnectiCare Member ID Number: _____ Subscriber's name if other than above: _____

I would like to request copies of the following documents, if they are on file at ConnectiCare:
(Please ✓ all that apply).

RECORDS REQUESTED		DATE(S)
ENROLLMENT		
1. Enrollment/Change Form	<input type="checkbox"/>	_____
2. Student Verification Form	<input type="checkbox"/>	_____
3. Power of Attorney	<input type="checkbox"/>	_____
4. Divorce Decree/Custody Documents	<input type="checkbox"/>	_____
5. CCI65 Enrollment Letters (Denials, Verification)	<input type="checkbox"/>	_____
PAYMENT (Billing) / CLAIMS		
1. Collection Letters	<input type="checkbox"/>	_____
2. Premium Bills (Direct Pay)	<input type="checkbox"/>	_____
3. COBRA Letters	<input type="checkbox"/>	_____
4. Explanation of Payments (EOPs)	<input type="checkbox"/>	_____
5. Explanation of Benefits (EOBs)	<input type="checkbox"/>	_____
6. Claim Forms	<input type="checkbox"/>	_____
7. Benefit Denial Correspondence	<input type="checkbox"/>	_____
CASE MANAGEMENT / HEALTH MANAGEMENT		
1. Physician/Provider Correspondence	<input type="checkbox"/>	_____
2. Clinical Information	<input type="checkbox"/>	_____
3. Referral Information	<input type="checkbox"/>	_____
4. Authorization for Services	<input type="checkbox"/>	_____
5. Member Correspondence	<input type="checkbox"/>	_____
GRIEVANCES AND APPEALS		
1. Member Correspondence	<input type="checkbox"/>	_____
2. Physician/Provider Correspondence	<input type="checkbox"/>	_____
3. Appeal Decision Letter	<input type="checkbox"/>	_____
4. Other Correspondence	<input type="checkbox"/>	_____
BEHAVIORAL HEALTH		
1. Claim Forms	<input type="checkbox"/>	_____
2. Authorization for Service	<input type="checkbox"/>	_____
3. Referral Information	<input type="checkbox"/>	_____
4. Correspondence (except psychotherapy notes)	<input type="checkbox"/>	_____

PHARMACY

- 1. Claim Information _____
- 2. Authorization for Services _____
- 3. Correspondence _____
- 4. Pharmacy Profile _____

RADIOLOGY

- 1. Claim Information _____
- 2. Authorization for Services _____
- 3. Correspondence _____
- 4. Referral Information _____

HOME HEALTH/DURABLE MEDICAL EQUIPMENT

- 1. Claim Information _____
- 2. Authorization for Services _____
- 3. Correspondence _____
- 4. Referral Information _____

SPEECH, OCCUPATIONAL, PHYSICAL THERAPY

- 1. Claim Information _____
- 2. Authorization for Services _____
- 3. Correspondence _____
- 4. Referral Information _____

VISION BENEFITS

- 1. Claim Information _____
- 2. Authorization for Services _____
- 3. Correspondence _____
- 4. Referral Information _____

OTHER (please specify and indicate dates)

DELIVERY OPTIONS

I would prefer:

- to pick up the copies. Please call me at _____ when they are ready.
- that ConnectiCare mail the copies to me at the above address or the following address:

Signature Required

Signature

Date Signed

Printed Name

Subscriber Name

Please mail this form to: ConnectiCare, Inc., 175 Scott Swamp Road
Farmington CT, 06032-3124
Attention: Member Services