



**REQUEST FOR ACCESS TO MEMBER’S DESIGNATED RECORD SET**

The AvMed Designated Record Set (DRS) is available to you beginning April 14, 2003 in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Standards for Privacy of Individually Identifiable Health Information (the Privacy Rule) effective April 14, 2003. It includes information collected from April 14, 2003 forward.

Please complete all of the following information:

Member Name: \_\_\_\_\_ ID Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Please send me a copy of my Designated Record Set.

I hereby certify that I am the above named AvMed member.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Or:

I hereby certify that I am the appointed representative of the above named AvMed member. I have attached the following documentation (please describe) \_\_\_\_\_

\_\_\_\_\_ of my appointment as representative:

Representative Name: (please print) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Members may access specific PHI via AvMed’s Web Site. If you are seeking information regarding specific services or payment for services you may find information available that meets your needs by visiting AvMed on-line at [www.avmed.org](http://www.avmed.org).

We may impose a reasonable, cost-based fee for additional requests of this DRS that will include the cost of copying and include the cost of supplies, labor, postage and preparing an explanation or summary of the protected health information.

Please return this form to:

**AvMed Health Plans  
PO Box 569008  
Miami, FL 33256**

**We will review your request and respond within 30 days of receiving your request.**

The DRS includes Protected Health Information (PHI) that is used in whole or in part, by or for AvMed to make decisions about members. It includes information pertaining to April 14, 2003 forward. AvMed has defined the DRS to consist of the following information:

**A. Enrollment Information**

1. Member Name
2. Member Current Address (Street Address, City, State, Zip Code)
3. Member ID Number
4. Currently Assigned PCP Name And Number
5. Employer Group Name
6. Member Effective Date
7. Member Termination Date (if applicable)

**B. Claims Information**

1. Claim Header Information
  - a) Claim Number
  - b) Provider Of Service Name
  - c) Claim Amount Paid
2. Claim Detail Information
  - a) Service Number
  - b) Date of Service
  - c) CPT-4 Description/UB Revenue Description
  - d) Primary ICD-9 Description
  - e) Service Amount Paid

**C. Health Plan Denied Medically Related Authorization Information. Only denied authorizations will be displayed.**

1. Authorization Number
2. Authorization Request Date
3. "Provider Referring To" Name
4. "Provider Referred To" Name
5. ICD9 Diagnosis Description

**D. Pharmacy Claims Information**

1. Claim Number
2. Date Prescription Filled
3. NDC Code
4. Label Name
5. Metric Quantity
6. Pharmacy Name

**E. Participation In Care Management Programs**

1. Care Management Program Name
2. Program Participation Begin Date
3. Program Participation End Date