Member Name:		
Address:		
City:	State:	Zip Code:
Date of Birth:	Plan ID Number:	
Phone Number:	Email Address:	
Member Signature:		Date:
Legal Representative Signature: *(if applicable)*		Date:
Relationship to Member:		

I would like an accounting of disclosures for the following timeframe:
(Please note: The maximum timeframe that can be requested is six years prior to the date of the request)

From: _____ To: _____

Fees:
First request in a 12-month period – No charge
Subsequent requests – available upon request

I understand that there may be a fee for this accounting. I also understand that the accounting will be provided to me within 60 days unless I am notified in writing that an extension of up to 30 days is needed.

Submit this form to The Health Plan of West Virginia, 1110 Main Street, Wheeling WV 26003 Attn: Compliance Department or email to HIPAA@healthplan.org.

FOR THP USE ONLY:

Date received:_____ Date sent: _____

Extension requested: ☐No ☐Yes, Reason: _____

Member notified in writing on this date: _____