

Detailed Claim Information:

- All itemized/detailed claims history, **or**
- Itemized/detailed claims history filed from: _____/_____/_____ To _____/_____/_____

Month Day Year Month Day Year

Medical Care Provider for above dates: _____
 (Name of provider, clinic, or facility)

- Case or Medical Management Records

These records include information obtained from your health care providers, as well as information concerning certification of requested health services. Please specify the following details:

- All Case/Medical Management Records, **or**
- Records from: _____/_____/_____ To: _____/_____/_____

Month Day Year Month Day Year

- Other records (*please provide detailed description*):

SECTION C: Request to inspect or obtain copies of records.

Do you wish to:

- Inspect these records at the office of ACS Benefit Services, Inc., 8025 North Point Blvd. Winston Salem, NC 27106?
- OR**
- Obtain copies of these records?
 At this time, ACS can provide the records only in paper form. ACS will charge you a fee of \$10, plus \$0.05 per page to copy these records.

If you requested to obtain copies, do you wish to:

- Pick up the copies at the office of ACS Benefit Services, Inc., 8025 North Point Blvd. Winston Salem, NC 27106?
- OR**
- Have ACS mail the copies to you?
 If ACS mails the copies to you, such copies will be mailed to your address that ACS has on file from the Health Plan. ACS will also charge you for the cost of the postage for mailed copies.

If you request copies of your records, ACS will advise you of the charges once ACS has compiled the records. ACS will release the records to you upon receipt of your payment.

If you want ACS to provide access to or copies of your records to any person other than you or your personal representative, you must provide ACS with a signed authorization in addition to this request. Please contact the Privacy Official of the Employer's Health Plan for an Authorization Form.

Signature of Requestor: _____ Date: _____

SECTION D:

If signed by an individual other than the Member:

Print your full name: _____

Relationship To Member (i.e. parent, personal representative, etc.) _____

Describe your authority to act for the Member (e.g. power of attorney, court order, parent of minor child, etc.):

You must attach the legal document naming you as the personal representative if you have not previously submitted it.

RETURN THIS REQUEST TO THE PRIVACY OFFICIAL AT THE OFFICE OF THE EMPLOYER

Received By: _____ Date: _____

(Privacy Official – Employer's Office)

Employer's Name: _____