Indiana Farm Bureau Health Plans

Indiana Farm Bureau HealthPlans
1-888-964-0854
infbhealthplans.com

REQUEST FOR MEDICAL RECORDS

Attention Provider: Any expense incurred in obtaining medical records is to be paid by the **patient**.

Date: _____
Primary Applicant Name: _____
Address: _____
City, ST, Zip: _____

Patient Name:_____
DOB: _____
County Office: _____

The following medical information is a requirement for children, **3 months thru 25 months of age**, who are applying for coverage with Farm Bureau Health Plans and can be submitted along with submitting health coverage application.

This information submitted may result in the Farm Bureau Health Plans Medical Underwriting department requesting further medical information to adequately underwrite your application. Prompt return of **all** information requested below is necessary to complete the underwriting procedure.

Medical information needed: COPY OF MEDICAL RECORDS REGARDING ALL PEDIATRIC VISITS FROM BIRTH TO PRESENT TO INCLUDE IMMUNIZATION HISTORY

Diagnosis, condition or problem: _____ Date of onset:_____

What type of treatment did he/she receive? Please explain: _____

_____

List any medication(s) taken:_____

Are they currently receiving treatment or taking medication? ☐ **Yes** ☐ **No**

If "Yes," is condition controlled with treatment or medication? ☐ **Yes** ☐ **No**

If "No," what is the stop date of treatment or medication? _____ Is recovery complete? ☐ **Yes** ☐ **No**

What is current status or prognosis? _____

_____ _____
Applicant Signature **Date**

_____ _____ _____
Physician Name (Please Print) **Physician Signature** **Date**

Please submit this form and medical records to INFBHP. See attached HIPAA Authorization Form.

Email: underwritingforms@fbhpservices.com | **Fax: 1-**931-560-4304

Applicant is encouraged to keep a personal copy of all medical records submitted to INFBHP. To obtain a copy of medical records from INFBHP, the applicant must contact the INFBHP Privacy Office. There will be a charge for the return of medical records.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This authorization complies with the HIPAA Privacy Regulations

Patient First Name _____ **Patient Last Name** _____

Patient SSN _____ **Patient DOB** _____

Address _____

A. Purpose

This disclosure is at my request for the purposes of underwriting, premium determination, or claims administration or adjudication, including without limitation, appraising Patient's application for health coverage and determining eligibility for enrollment and/or claims payment.

B. Who May Disclose

I hereby authorize the following persons or entities to release health information: (1) licensed health care professionals that have treated or are treating the Patient; (2) allied health care professionals that have treated or are treating the Patient; (3) health care facilities that have treated or are treating the Patient; (4) mental health care facilities and professionals that have treated or are treating the Patient; (5) Indiana Farm Bureau Insurance; (6) _____

C. Information to be Disclosed

The information requested pertains to medical information relevant to the Patient's suitability for health coverage or any claim made against such health coverage. This includes any and all information concerning the Patient's medical care, treatment or advice, including medical or other care records, diagnosis & pharmacy information deemed necessary by Indiana Farm Bureau Health Plans to issue health coverage or determine the Patient's eligibility for enrollment and/or claims payment. This specifically authorizes the release of information relating to: Substance abuse (including drug and/or alcohol abuse); Mental health (excluding psychotherapy notes); and HIV related information (AIDS related testing or treatment). The Patient/Patient's Representative specifically authorizes the disclosure and release of his/her entire medical record upon request of Indiana Farm Bureau Health Plans.

D. Please release the information to the following organizations

Indiana Farm Bureau Health Plans
PO Box 1424, Columbia, TN 38402-1424

E. Right to Refuse

I acknowledge that signing this Authorization is voluntary and I have the right to refuse to sign this Authorization; however, if I refuse to sign this Authorization, I understand that Indiana Farm Bureau Health Plans may not be able to gather the information necessary to determine if I am, or an unemancipated minor child is, eligible for coverage by Indiana Farm Bureau Health Plans. Further, I understand that I may refuse to sign this Authorization and that a health care provider that is a covered entity may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this Authorization.

F. Revocation

I acknowledge that I may revoke this Authorization at any time by sending a written notice to the Indiana Farm Bureau Health Plans Privacy Officer at P.O. Box 1424, Columbia, TN 38402-1424. However, the revocation will not have any effect on any disclosures that a person or entity may have made in reliance on this Authorization before the revocation was received. Furthermore, I acknowledge that if I revoke this Authorization my application for health coverage may be declined or claims for benefits may be denied.

G. Expiration

I acknowledge that unless I revoke this Authorization, it will remain in effect from the date hereof and continue in effect until the latter of 1) a period of one (1) year from the date of execution, or 2) until the application is denied or, 3) if the application is approved, for as long as necessary for any claims to be adjudicated.

H. Redisclosure

I acknowledge that information used or disclosed in accordance with this Authorization may no longer be protected by federal law, and could be redisclosed by the receiving party, but will not be redisclosed by Indiana Farm Bureau Health Plans except as authorized by me or as required by law.

I. Certification

I certify that I am (check whichever applies):

☐ the Patient, and the identification that I have provided is true and correct.

☐ the Patient's authorized representative, with authority to consent to treatment and release of information on behalf of the Patient, and the identification that I have provided is true and correct. My relationship to the Patient is that of:_____

Signature: _____ **Signed this _____ day of _____, 20_____.**

SSN: _____ **DOB:** _____

Print Name (Patient / Legal Guardian / Patient Representative): _____