How to Request a Copy of Your Records FEP

Instructions

Use this form to ask for a copy of a member or applicant's personal information in our files.

Do one of the following:

- Call Customer Service at the number listed on the back of your Member ID card if you need:
  - A copy of an Explanation of Benefits (EOB) for a claim
  - Information on a claim
  - A summary of claims that we have paid for the member
  - A copy of the member's enrollment application
  - Certification (proof) of the member's health coverage

- Fill out the included form to get a copy of any other Premera record we may have in our files. If you have questions on how to use this form, contact Customer Service.

Note: Not all requests will be granted. For example, federal law may not allow us to release certain records.

Notice of Privacy Practices

Our Notice of Privacy Practices describes how we may use and disclose member personal information and members' rights concerning it. This notice is on our website at *www.premera.com*. If you need a paper copy, call Customer Service at the number listed on the back of your Member ID card.

Questions? Call Customer Service:

FEHB: 800-562-1011 (TTY: 711)
PSHB: 800-550-1722 (TTY: 711)

BlueCross BlueShield
Federal Employee Program

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Instructions

- Please fill out all the information below.
- **Please print clearly**.
- Make a copy for your records and send the completed form in one of three ways:
  1. Secure Messaging through your MyBlue account at fepblue.org
  2. Fax: 877-202-3149
  3. Mail: FEP Appeals, PO Box 91058, Seattle, WA 98111-9158

Please note: We will mail your copies within **30** days of getting this form, unless we notify you in writing within those 30 days that we need 30 more days and why. We will also let you know if we need to charge a fee for any copies.

A. Member information

Member's name: first name, middle initial, last name	Member's date of birth (mm/dd/yyyy)
Subscriber's name: first name, middle initial, last name	Member ID number

B. Your information if you are not the member

Important: If you are not the member, you must be the member's parent, legal guardian, or holder of the power of attorney (POA). If you are the legal guardian or holder of POA, please send legal proof with this form.
Your name: first name, middle initial, last name
I am not the member. I am the (select one): ❍ Legal guardian ❍ Parent ❍ Holder of Power of Attorney/Legal Representative (must attach supporting legal documentation)

C. Mailing address – Tell us to whom and where you want us to send copies and other mail for this member.

Send to - select one ❍ Member ❍ Parent, legal guardian, or holder of the POA ❍ Another person			
Full name: first name, middle initial, last name			
Mailing address	City	State	ZIP code
Daytime phone – include area code			

D. Type of information you are requesting

Give a general description of the information you are requesting

Date(s) of the record(s) - This could be a range of dates or multiple dates.
Provider(s) name(s)
Medical condition
Service or treatment

E. Signature – Print this form then sign it below.

Who must sign this form

- For a member aged 12 or younger, the parent or legal guardian can sign.
- For a member aged 13 or older, the member must sign, unless a court with jurisdiction has deemed the member incapable of consenting to his or her own services and has appointed a legal guardian.

Sign your name X_____	Printed name
	Date signed (mm/dd/yyyy)