RESET

Braven HEALTH

Request For Accounting Of Disclosures

Read instructions on p. 2 before completing this form. ALL FIELDS MUST BE COMPLETED.

A separate form is required for each member on the policy or coverage, as applicable. Please print legibly, except where signature is required. To request an Accounting of Disclosures of your Private Information by Braven Health and its business associates, please complete the information below, sign in the space provided and return to: Braven Health, Attn: HIPAA Team, P.O. Box 1458, Newark, New Jersey 07101-1458, or via fax at 973-274-2358.

SECTION A: MEMBER INFORMATION

Name *(☐ Subscriber ☐ Dependent):* _____

Bravn Health Member ID #: _____ Date of Birth: _____ / _____ / _____
MM DD YYYY

Address (on file): _____

City: _____ State: _____ ZIP: _____

Telephone #: _____-_____-_____

SECTION B: REQUEST FOR ACCOUNTING OF DISCLOSURES

I, _____, hereby request an accounting of private information disclosures by Braven
(member / personal representative)

Health and its business associates for the time period of: Date _____ / _____ / _____ to Date _____ / _____ / _____
MM DD YYYY

I understand that this accounting request is limited to disclosures made no greater than six (6) years prior to the date on which the accounting is requested and applies only to those disclosures that privacy regulations require to be accounted for. I also understand that Braven Health may not process this request if the right to the accounting has been suspended by a health oversight agency or law enforcement official.

_____ Date: _____ / _____ / _____
MM DD YYYY

Signature of ☐ Member / ☐ Personal Representative*

_____

Print Name

*Check the appropriate box to indicate whether the signature above is that of the Member or the Personal Representative. If the requestor is other than the member, the requestor must sign form and attach documentation showing authorization to act on behalf of member, unless the requestor has been previously registered with Braven Health as a personal representative.

INSTRUCTIONS
REQUEST FOR ACCOUNTING OF DISCLOSURES

General Instructions: All fields are required to be completed unless otherwise specified.

This form must be completed when a member wants to request an accounting of disclosures of private information made by Braven Health. These will not include disclosures of private information made for purposes of treatment, payment or healthcare operations, disclosures to the member to whom the private information pertains, disclosures to a personal representative of the member, or as stipulated by federal or state privacy laws.

All required legal documents will undergo a validation process by Braven Health. A separate form and documentation is required for each member on the coverage, as applicable. Accountings of disclosures will be delivered by US Mail.

Section A. Member Information

This section requests information related to the member. Since this information is used for both identification and verification purposes, the information included in this section should match the most current information for the member/subscriber in Braven Health's systems.

Please, be aware that this form may be denied if the information on the form does not match the information in our systems or if the form is not **fully** completed.

Section B: REQUEST FOR ACCOUNTING OF DISCLOSURES

This section requires the signature of an authorized person in order to release requested private information. Specify the timeframe that disclosures are being requested for noting that the specified period cannot exceed six (6) years from the date of the request.

Mail this form to:

Braven Health
Attn: HIPAA Unit
PO Box 1458
Newark, NJ 07101-1458

Or Fax to: (973)274-2358