

ACCOUNTING REQUEST FORM



WYOMING

Purpose: This form is used to document an Individual's request for an accounting of Disclosures of Protected Health Information.

SECTION A: Individual requesting Disclosure accounting

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Subscriber Number: _____ Social Security Number: _____

SECTION B: To the Individual—Please read the following.

You have the right to an accounting of the Disclosures Blue Cross Blue Shield of Wyoming (BCBSWY), or its Business Associates have made of your Protected Health Information. The accounting period is the six (6) years prior to your request. You are not entitled to an accounting for Disclosures BCBSWY or its Business Associates made to carry out your Treatment, Payment for that Treatment or BCBSWY's Healthcare Operations, or Disclosures BCBSWY or its Business Associates made to you, your Personal Representatives, your family, close friends and others involved in your Healthcare. You are also not entitled to an accounting for Disclosures BCBSWY or its Business Associates made for national security or intelligence purposes, or Disclosures made to certain law enforcement agencies.

You are entitled to one free Disclosure accounting each 12 months. BCBSWY will charge you \$_____ for each additional Disclosure accounting you request during the same twelve (12) month period.

To request a Disclosure accounting, please complete the signature block below.

SECTION C: Signature

I request an accounting of the accountable Disclosures of my Protected Health Information made within the six (6) years prior to the date of this request. I understand that I am entitled to one free Disclosure accounting each twelve (12) months. I agree to pay \$_____ for this Disclosure accounting if I have already received a Disclosure accounting from BCBSWY within the previous twelve (12) months.

Signature _____ Date _____

SECTION D: Personal Representative

If this request is by a Personal Representative on behalf of the Individual, complete the following:

Personal Representative's Name

Relationship to Individual

YOU ARE ENTITLED TO A COPY OF THIS REQUEST

Form Submission Instructions

Steps for returning a completed form may depend on whether you obtained the form online, received it by email or through another means. Please read the instructions below to decide which submission method suits you best. If the form specifies a preferred method, please follow those directions instead.

Online: Download the form and fill it out in the free Adobe Reader (get.adobe.com/reader) or fill out the form online if that option exists and then download it to your device. Save the completed form to your computer or device.

Submission:

BY MAIL – Print and mail the completed form to:

Blue Cross Blue Shield of Wyoming, PO Box 2266, Cheyenne, WY 82003.

BY EMAIL – Send the form and any required documentation as attachments to a BCBSWY email address, if one is provided.

BY SECURE UPLOAD – Follow the directions below to securely upload your form at Member.YourWyoBlue.com (member.yourwyoblue.com). Click the link or scan the QR code.

After logging in to your Member.YourWyoBlue.com account:

STEP 1
Click on the **Support** button on the menu bar. Scroll down and select **Send a Message**.

STEP 2
Select the plan the form applies to from the list in the panel. Click **Continue**.

STEP 3
Select General–Other as the **Topic**.

STEP 4
Fill in **Callback Preferences** (*Phone number, *Best time to call, and *May we leave a message...?).

STEP 5
Type any message in the **Message** box.

STEP 6
Click on the paperclip icon next to message box to attach a completed form from its location on your device.

STEP 7
Click on the **Send** button to send your message and upload your saved form securely.

