Clover Health

Request for Accounting of Disclosures of Protected Health Information

Use this form to request a report called an "accounting of disclosures" stating when and why your Protected Health Information (PHI) was shared for certain purposes.

Section 1: Member Information	
Name:	
Date of Birth:	**Phone Number:**
Clover Member ID #:	

Section 2: Request for Accounting of Disclosures

Clover Health is required to track and report to you upon request all disclosures of PHI made on or after April 14, 2003, except for disclosures that are:

- For treatment, payment, or healthcare operations or as part of a limited data set;
- To you or someone legally authorized to act on your behalf;
- To anyone pursuant to an authorization form completed and signed by you or your authorized representative;
- For national security or intelligence purposes or to correctional institutions or law enforcement officials; or
- Incidental to a use or disclosure otherwise permitted or required by law.

I am requesting an accounting of disclosures of my PHI for the dates below:

_____ to _____

MM/DD/YYYY MM/DD/YYYY

PLEASE FILL OUT THE REVERSE SIDE OF THIS FORM.

Section 3: Signature of Member or Authorized Representative

By signing this form, I understand that Clover Health has sixty (60) days to respond to my request, starting from the day the request is received, unless I am notified in writing that an extension of up to thirty (30) days is needed.

I understand that if my request for an accounting of disclosures is denied, I may have the right to request a reconsideration of the decision.

I understand that any form returned to Clover Health incomplete will be returned to me for completion and my accounting request will not be processed until the form is completed.

❑ Check here if you are signing as an authorized personal representative and provide your information below. Please attach the appropriate documentation (e.g., power of attorney, court order). Please note: the documentation must be validated by our Legal department before an authorized representative signature can be accepted.

Printed Name: _____

Relationship to Member: _____

Signature:	**Date:**

Please mail the completed form to:
Clover Health
P.O. Box 21164
Eagan, MN 55121

Or fax this form to:
Attn: Mailroom
1-866-508-0865

Clover Health is a Preferred Provider Organization (PPO) and a Health Maintenance Organization (HMO) with a Medicare contract. Enrollment in Clover Health depends on contract renewal.