Claims Profile Request Form

Please Note: <u>All fields are required</u>. Incomplete or incorrect forms will be returned.

Claim profiles could contain sensitive medical information (such as the diagnosis, testing and/ or treatment of HIV/AIDs, substance abuse, genetic testing and/or venereal diseases) unless otherwise directed to omit such data. Tufts Health Plan reserves the right, in accordance with applicable law, to delete certain highly sensitive, medical claims/information from profiles.

Type of Profile Request: *(check all that apply)*

☐ **Medical** Date Range of Data Requested _____/_____/_____ to _____/_____/_____

☐ **Prescription** Date Range of Data Requested _____/_____/_____ to _____/_____/_____

Member / Legal Representative Information: *(one form per member)*		
Member Name *(please print)*		
Member ID Number		
Member Date of Birth	_____/_____/_____ *(month/day/year)*	
Member Signature (or Legal Representative*) Sign & Date Here →		**Date:**
(If applicable) **Print Name of Legal Representative**		
(must be over 18 years of age) **Relationship to Member**		

* A Legal Representative is defined as a parent of a minor child, a legal guardian, a person acting in loco parentis (in place of parent) of a minor child or any other person with legally granted authority, such as a Health Care Proxy or Durable Power of Attorney or Power of Attorney. To be recognized as a legal representative (other than a parent of minor child) by Tufts Health Plan, a separate authorization form must be completed and on file with us before this request can be completed.

I represent that the signature above is my own or that I have been legally authorized to affix the signature. I recognize that signing the name of another person to this document without legal authorization may be subject to prosecution.

Contact Information for Member / Legal Representative	
Daytime Phone Number	
Report will be mailed to the address on record, unless otherwise specified by providing an address below:	
Address:	
City, State, Zip Code	

Please Fax this Form to:	**617-673-0380**	**or mail this form to:**	**Tufts Health Plan – Member Services P.O. Box 9170 Watertown, MA 02471-9170**

Internal Use Only:

Tufts HP Representative Name: _____ Ext.: _____

SMS Initials: _____ Adm. Sup. Initials: _____ Date Completed: _____

Partial Record Set _____ Full Record Set _____