MEDICAL/PRESCRIPTION CLAIMS PROFILE REQUEST FORM

US FAMILY HEALTH PLAN

Please Note: All fields are required. Incomplete or incorrect forms will be returned.

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 11 digit ID Number (found on Member's USFHP ID card)	Member Date of Birth (MM/DD/YYYY)
Member or Legal Representative* Signature (must be over 18 years of age)	Date

If applicable:

Legal Representative Name (please print)

Legal Representative Relationship to Member (please check one)

❑ Spouse ❑ Parent ❑ Guardian ❑ Other Please specify_____

*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 USFHP, 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. Signature requirements are intended to protect member privacy.

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. USFHP reserves the right, in accordance with applicable law, to delete certain highly sensitive, medical claims/ information from profiles.

CONTACT INFORMATION

Member/Legal Representative Daytime Phone Number ( ) –

Please mail Claim Profile Report(s) to the address below:

_____

_____

_____

Return completed form to:
US Family Health Plan, P.O. Box 495, Canton, MA 02021-0495

For internal use only

Rep Name _____ Extension _____

SMS Init: _____ Admin Spvr Init: _____ Date Completed: _____