Farm Bureau Health Plans
1-877-874-8323
www.fbhealthplans.com

REQUEST FOR MEDICAL RECORDS

ATTENTION PROVIDER: Any expense incurred in obtaining medical records is to be paid by the patient.

Date: _____

Name _____

Address _____

City, St. Zip _____

Patient Name _____

DOB _____

County _____

The following medical information is a requirement for children, 3 months - 25 months, who are applying for coverage with Farm Bureau Health Plans and can be submitted with your application.

This information submitted may result in the Farm Bureau Health Plans Medical Underwriting department requesting further medical information to adequately underwrite your application. Prompt return of **all** information requested below is necessary to complete the underwriting procedure. The applicant is encouraged to keep a personal copy of all medical records submitted to Farm Bureau Health Plans. To obtain a copy of medical records from Farm Bureau Health Plans, the applicant must contact the Farm Bureau Health Plans Privacy Office. There will be a charge for the return of medical records.

Medical information regarding: COPY OF MEDICAL RECORDS REGARDING ALL PEDIATRIC VISITS FROM BIRTH TO PRESENT TO INCLUDE IMMUNIZATION HISTORY OR STATEMENT OF INTENT TO IMMUNIZE

Date of onset: _____ Diagnosis, Condition, or problem: _____

What type of treatment did he/she receive? Please explain: _____

_____

List any medication(s) taken: _____

Are they currently receiving treatment or taking medication? _____ Yes _____ No
If "Yes," is condition controlled with treatment or medication. _____ Yes _____ No Please explain: _____

_____

If "No," what is the stop date of treatment or medication: _____ Is recovery complete? _____ Yes _____ No

What is the current status or prognosis:_____

_____ _____
Member Signature Date

Physician's Name (Please print) _____

_____ _____
Physician's Signature Date

Attention: Please email medical records to underwritingforms@fbhealthplans.com
For additional medical record submission options, please call 1-877-874-8323.
See the attached Patient Authorization for Release of Protected Health Information.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This authorization complies with the HIPAA Privacy Regulations

Patient First Name _____ **Patient Last Name** _____

Patient SSN _____ **Patient DOB** _____

Address _____

A. Purpose

This disclosure is at my request for the purposes of underwriting, premium determination, or claims administration or adjudication, including without limitation, appraising Patient's application for health coverage and determining eligibility for enrollment and/or claims payment.

B. Who May Disclose

I hereby authorize the following persons or entities to release health information: (1) licensed health care professionals that have treated or are treating the Patient; (2) allied health care professionals that have treated or are treating the Patient; (3) health care facilities that have treated or are treating the Patient; (4) mental health care facilities and professionals that have treated or are treating the Patient; (5)_____

C. Information to be Disclosed

The information requested pertains to medical information relevant to the Patient's suitability for health coverage or any claim made against such health coverage. This includes any and all information concerning the Patient's medical care, treatment or advice, including medical or other care records, diagnosis & pharmacy information deemed necessary by Farm Bureau Health Plans to issue health coverage or determine the Patient's eligibility for enrollment and/or claims payment. This specifically authorizes the release of information relating to: Substance abuse (including drug and/or alcohol abuse); Mental health (excluding psychotherapy notes); and HIV related information (AIDS related testing or treatment). The Patient/Patient's Representative specifically authorizes the disclosure and release of his/her entire medical record upon request of Farm Bureau Health Plans.

D. Please release the information to the following organizations

Farm Bureau Health Plans
PO Box 313, Columbia TN 38402-0313

E. Right to Refuse

I acknowledge that signing this Authorization is voluntary and I have the right to refuse to sign this Authorization; however, if I refuse to sign this Authorization, I understand that Farm Bureau Health Plans may not be able to gather the information necessary to determine if I am, or an unemancipated minor child is, eligible for coverage by Farm Bureau Health Plans. Further, I understand that I may refuse to sign this Authorization and that a health care provider that is a covered entity may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this Authorization.

F. Revocation

I acknowledge that I may revoke this Authorization at any time by sending a written notice to the Farm Bureau Health Plans Privacy Officer at P.O. Box 313, Columbia, TN 38402-0313. However, the revocation will not have any effect on any disclosures that a person or entity may have made in reliance on this Authorization before the revocation was received. Furthermore, I acknowledge that if I revoke this Authorization my application for health coverage may be declined or claims for benefits may be denied.

G. Expiration

I acknowledge that unless I revoke this Authorization, it will remain in effect from the date hereof and continue in effect until the later of 1) a period of one (1) year from the date of execution, or 2) until the application is denied or, 3) if the application is approved, for as long as necessary for any claims to be adjudicated.

H. Redisclosure

I acknowledge that information used or disclosed in accordance with this Authorization may no longer be protected by federal law, and could be redisclosed by the receiving party, but will not be redisclosed by Farm Bureau Health Plans except as authorized by me or as required by law.

I. Certification

I certify that I am (check whichever applies):

☐ the Patient, and the identification that I have provided is true and correct.

☐ the Patient's authorized representative, with authority to consent to treatment and release of information on behalf of the Patient, and the identification that I have provided is true and correct. My relationship to the Patient is that of:_____

Signature:_____ **Signed this**_____ **day of**_____**, 20**_____**.**

SSN: _____ **DOB:** _____

Print Name (Patient / Legal Guardian / Patient Representative): _____