ConnectiCare

Request for Personal Information Form

To obtain copies of any personal information ConnectiCare may have on file regarding you, please provide the information requested below and return completed form to ConnectiCare, 175 Scott Swamp Road, Farmington, CT 06032-3124. Your copies will be mailed or available for pick-up within thirty (30) days after ConnectiCare's receipt of this completed form. If you are requesting information on behalf of someone other than yourself or your minor child, please contact Member Services at 1-800-251-7722 to obtain an authorization form.

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____

ConnectiCare Member ID Number: _____ Subscriber's name if other than above: _____

I would like to request copies of the following documents, if they are on file at ConnectiCare:
(Please ✔ all that apply).

RECORDS REQUESTED		DATE(S)
ENROLLMENT		
1. Enrollment/Change Form	☐	_____
2. Student Verification Form	☐	_____
3. Power of Attorney	☐	_____
4. Divorce Decree/Custody Documents	☐	_____
5. Enrollment Letters (Denials, Verification)	☐	_____
PAYMENT (Billing) / CLAIMS		
1. Collection Letters	☐	_____
2. Premium Bills (Direct Pay)	☐	_____
3. COBRA Letters	☐	_____
4. Claim Summary or Explanation of Benefits (EOBs)	☐	_____
5. Claim Forms	☐	_____
6. Benefit Denial Correspondence	☐	_____
CASE MANAGEMENT / HEALTH MANAGEMENT		
1. Physician/Provider Correspondence	☐	_____
2. Clinical Information	☐	_____
3. Referral Information	☐	_____
4. Authorization for Services	☐	_____
5. Member Correspondence	☐	_____
GRIEVANCES AND APPEALS		
1. Member Correspondence	☐	_____
2. Physician/Provider Correspondence	☐	_____
3. Appeal Decision Letter	☐	_____
4. Other Correspondence	☐	_____
BEHAVIORAL HEALTH		
1. Claim Forms	☐	_____
2. Authorization for Service	☐	_____
3. Referral Information	☐	_____
4. Correspondence (except psychotherapy notes)	☐	_____

PHARMACY

1. Claim Information ☐ _____
2. Authorization for Services ☐ _____
3. Correspondence ☐ _____
4. Pharmacy Profile ☐ _____

RADIOLOGY

1. Claim Information ☐ _____
2. Authorization for Services ☐ _____
3 Correspondence ☐ _____
4. Referral Information ☐ _____

HOME HEALTH/DURABLE MEDICAL EQUIPMENT

1. Claim Information ☐ _____
2. Authorization for Services ☐ _____
3. Correspondence ☐ _____
4. Referral Information ☐ _____

SPEECH, OCCUPATIONAL, PHYSICAL THERAPY

1. Claim Information ☐ _____
2. Authorization for Services ☐ _____
3. Correspondence ☐ _____
4. Referral Information ☐ _____

VISION BENEFITS

1. Claim Information ☐ _____
2. Authorization for Services ☐ _____
3. Correspondence ☐ _____
4. Referral Information ☐ _____

OTHER (please specify and indicate dates)

_____

_____

DELIVERY OPTIONS

I would prefer:

☐ to pick up the copies. Please call me at _____ when they are ready.
☐ that ConnectiCare fax the copies to me at: _____.
☐ that ConnectiCare mail the copies to me at the above address or the following address:
_____.
☐ that ConnectiCare securely email the copies to me at the following email address:
_____.

Signature Required

_____ _____
Signature Date Signed

_____ _____
Printed Name Subscriber Name

Please mail this form to: ConnectiCare, Inc., 175 Scott Swamp Road
Farmington, CT 06032-3124
Attention: Member Services