



Protected Health Information (PHI) ECHS Category - PHIA Access Request

Protected Health Information (PHI) means information about your health.
This form must be completed and signed to process this request.

1. Who is the Medicaid Member?

First name	Last name	Middle initial
Member ID number	Birth date (MM/DD/YYYY)	Phone number
Street		
City, state, ZIP code		

2. Description of a PHI Report

Once we get this signed request form, we will provide you with a PHI Report. The report will have the last 24 months of PHI data that we have. If you want PHI for different dates, fill in the dates below.

From: _____ To: _____

If you have Long Term Care (LTC) benefits and want that information, check the correct box below.

I want the report to include LTC information I only want LTC information in the report.

3. Where do you want this PHI Report to be sent?

Who is receiving this PHI Report? <input type="checkbox"/> Member <input type="checkbox"/> Member's Legal Representative <input type="checkbox"/> Member's Natural or Adoptive Parent
Print name of recipient
Recipient's street
City, state, ZIP code

Important Information:

- By signing this form, I allow Aetna to give PHI about the Member named in **Section 1** to the recipient named in **Section 3**.
- This approval is only for this request.
- This report may include information about chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable diseases, sexually-transmitted diseases, HIV/AIDS, and/or genetic marker.
- This PHI Report does not include psychotherapy notes.
- Information in this report could be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws.

4. Signature of Member or Authorized Representative

Signature	Date
Print name	
If a legal representative signed this form, describe the relationship: (parent, legal guardian, Power of Attorney, personal representative)	

Authorized Representative means you have legal proof that you can act for this person. A representative signs for a person who cannot legally sign on his or her own. If the member is less than 18 years old, a parent, or guardian should sign for the minor. If you are a representative signing this form you must send legal proof you can act for this person.

Do you have questions? We can help. Call Aetna Better Health of California at: 1-855-772-9076.

**Please sign and return this completed form to: Aetna HIPAA Member Rights Team
PO Box 14079
Lexington, KY 40512-4079**

Or you can fax it to: 859-280-1272

Please allow 30 days for our response.



AETNA BETTER HEALTH® OF CALIFORNIA

Nondiscrimination Notice

Discrimination is against the law. Aetna Better Health of California follows Federal civil rights laws. Aetna Better Health of California does not discriminate, exclude people, or treat them differently because of race, color, national origin, age, disability, or sex.

Aetna Better Health of California provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Aetna Better Health of California 24 hours a day, 7 days a week by calling **1-855-772-9076**. Or, if you cannot hear or speak well, please call **TTY 711**.

How to file a grievance

If you believe that Aetna Better Health of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Aetna Better Health of California. You can file a grievance by phone, in writing, in person, or electronically:

By phone: Contact Aetna Better Health of California 24 hours a day, 7 days a week by calling **1-855-772-9076**. Or, if you cannot hear or speak well, please call **TTY 711**.

In writing: Fill out a complaint form or write a letter and send it to:

Aetna Better Health of California
10260 Meanley Drive
San Diego, CA 92131

In person: Visit your doctor's office or Aetna Better Health of California and say you want to file a grievance.

Electronically: Visit Aetna Better Health of California website at aetnabetterhealth.com/california

Office of Civil Rights

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.

In writing: Fill out a complaint form or send a letter to:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Electronically: Visit the Office for Civil Rights Complaint Portal at
<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.

Multi-language Interpreter Services

ENGLISH: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call the number on the back of your ID card or **1-800-385-4104** (TTY: **711**).

SPANISH: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al número que aparece en el reverso de su tarjeta de identificación o al **1-800-385-4104** (TTY: **711**).

CHINESE: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電您的 ID 卡背面的電話號碼或 **1-800-385-4104** (TTY: **711**)。

VIETNAMESE: CHÚ Ý: nếu bạn nói tiếng việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Hãy gọi số có ở mặt sau thẻ id của bạn hoặc **1-800-385-4104** (TTY: **711**).

TAGALOG: PAUNAWA: Kung nagsasalita ka ng wikang Tagalog, mayroon kang magagamit na mga libreng serbisyo para sa tulong sa wika. Tumawag sa numero na nasa likod ng iyong ID card o sa **1-800-385-4104** (TTY: **711**).

KOREAN: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하의 ID 카드 뒷면에 있는 번호로나 **1-800-385-4104** (TTY: **711**) 번으로 연락해 주십시오.

ARMENIAN: Ուշադրություն: Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Ձանգահարե՛ք ձեր ID քարտի հետևի մասում գտնվող հեռախոսահամարով կամ **1-800-385-4104** (TTY (հեռախոսի)՝ **711**):

PERSIAN: اگر به زبان فارسی صحبت می کنید، به صورت رایگان می توانید به خدمات کمک زبانی دسترسی داشته باشید. با شماره درج شده در پشت کارت شناسایی یا با شماره **1-800-385-4104** (TTY: **711**) تماس بگیرید.

RUSSIAN: ВНИМАНИЕ: если вы говорите на русском языке, вам могут предоставить бесплатные услуги перевода. Позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки, или по номеру **1-800-385-4104** (TTY: **711**).

JAPANESE: 注意事項:日本語をお話になる方は、無料で言語サポートのサービスをご利用いただけます。ID カード裏面の電話番号、または**1-800-385-4104** (TTY: **711**)までご連絡ください。

ARABIC: ملحوظة: إذا كنت تتحدث باللغة العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل على الرقم الموجود خلف بطاقتك الشخصية أو عل **1-800-385-4104**(للصم والبكم: **711**)

PANJABI: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਵਿੱਚ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਉਪਲਬਧ ਹਨ। ਆਪਣੇ ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਨੰਬਰ ਜਾਂ **1-800-385-4104** (TTY: **711**) 'ਤੇ ਕਾਲ ਕਰੋ।

MON KHMER: ប្រយ័ត្ន: បស្ចឹមជាអ្នកនិយាយ ភាសាខ្មែរ, សេ វាជំនួយផ្នែកភាសា ដោយមិនគិតល្មើស គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ ទៅលេខនៅខាងក្រោយនៃ អត្តសញ្ញាណប័ណ្ណ (ID Card) របស់អ្នក ឬ **1-800-385-4104** (TTY: **711**) ។

HMONG: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau tus nab npawb xov tooj nyob rau sab qab ntawm koj daim ID lossis **1-800-385-4104** (TTY: **711**).

HINDI: ध्यान दें: यदि आप हिंदी भाषा बोलते हैं तो आपके लिए भाषा सहायता सेवाएं नि:शुल्क उपलब्ध हैं। अपने आईडी कार्ड के पृष्ठ भाग में दिए गए नम्बर अथवा **1-800-385-4104** (TTY: **711**) पर कॉल करें।

THAI: ข้อควรระวัง: ถ้าคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทรติดต่อหมายเลขที่อยู่ด้านหลังบัตร ID ของคุณ หรือหมายเลข **1-800-385-4104** (TTY: **711**)