UCONN HEALTH

(Patient Identification)

REQUEST: RESTRICT DISCLOSURE TO HEALTH PLAN/TERMINATION

- I request that UConn Health not disclose my protected health information (PHI) to my health plan or other third party insurance carrier.
- **I have read the Patient Right to Restrict Protected Health Information to Health Plan form.**
- The records of the restricted services/items listed below will not be released or billed to my health plans for the purposes of payment or health care operations.
- I am financially responsible for these restricted services/items and expect to pay out-of-pocket, in full, at the time of service in order for UConn Health to accept this restriction request.

Print Patient Name: _____

Print Patient Address: _____

For administrative use only:
Staff Must Fax Form Immediately to the following Departments:
For ALL UMG and JDH Services Fax to:
☐ **9-860-676-3450** *******ALL DIGITS MUST BE DIALED AS THIS IS NOT A 679 PREFIX**
For ALL Dental Services Fax to:
☐ **9-860-676-3451** *******ALL DIGITS MUST BE DIALED AS THIS IS NOT A 679 PREFIX**
PLEASE BE SURE THAT THE NUMBER (9) IS DIALED BEFORE THE FULL TELEPHONE NUMBER

Requested restriction:

Date of service: ____/____/_____ Provider of Care: _____

Services/Items to be restricted: _____

Total Charge Amount (or estimated amount): $_____
(I understand that I am responsible for full charges when finalized)

Signed by: _____Date:___/___/____Time: ___:___☐am ☐pm
☐Patient ☐Parent/Guardian/Conservator ☐Representative (specify):_____

Obtained by: _____Date:___/___/____Time: ___:____☐am ☐pm

Patient Termination: Sign below only if terminating requested restriction above.

You may terminate this restriction by signing this Termination of Restriction section.

Termination
Signed by: _____Date:___/___/___Time: ___:___☐am ☐pm
☐Patient ☐Parent/Guardian/Conservator ☐Representative (specify):_____

Obtained by: _____Date:___/___/____Time:___:___☐am ☐pm

Note: UConn Health may terminate this restriction by notifying you in writing if you fail to pay in full.

White – Chart Yellow – Patient

HCH2448

Patient Right to Restrict Protected Health Information to Health Plan

UConn Health
263 Farmington Ave
Farmington, CT 06030

John Dempsey Hospital Patient Financial Services Mail Code - 4034
University Physicians Patient Financial Services Mail Code - 6305
University Dentists Mail Code - 2820
Dental Clinics Mail Code - 2105

Dear Patient,

You have the right to request restrictions on whether UConn Health discloses (shares) your protected health information (PHI) with your health plan. **UConn Health is required to agree to your request** unless *the information is required to be disclosed to your health plan to comply with the law.* However, if you are requesting a restriction on a service that has already been disclosed to the health plan prior to your request for the restriction, such as in the case of prior authorization requirements, by signing the form titled ***"Request: Restrict Disclosure to Health Plan/Termination"***, you acknowledge your awareness of this previous disclosure. UConn Health will not share restricted PHI with your health plan but we will continue to share information with your providers. You are responsible for notifying all providers outside of UConn Health not to disclose these services to your health plan. In the event that previously restricted PHI is required to satisfy your health plan's requirement for medical necessity, prior authorization, or payment of a subsequent service, and that subsequent service has not been restricted and paid for by you, UConn Health is permitted to disclose such information. Therefore, if any of the previously restricted PHI would be part of a follow up visit at UConn Health, you need to ask for the restriction again for that follow up visit. This would include the need to request the restriction for any related laboratory or radiology service if the restriction applies to those ancillary services as part of your visit.

UConn Health is <u>only required</u> to honor your request not to disclose PHI to your health plan when:
You complete and sign the form titled ***"Request: Restrict Disclosure to Health Plan/Termination"***.

AND

At the time of service, you **<u>pay out of pocket in full</u>** the estimated cost of the service(s). If payment doesn't cover the full cost of service(s), you pay the remaining balance within 30 days of receipt of the bill for the service(s).

UConn Health <u>is not required</u> to honor your request when:
You do not pay in full, as outlined above. We will terminate your request for the restriction and notify you of this termination via certified letter. Termination will occur 30 days after the date of the certified letter. A copy of the certified letter will be stored in your medical record as validation of our termination of your original requested restriction.

OR

You request that the restriction be terminated. In order to terminate a previous request, you must contact the UConn Health - Health Information Management Department at 860-679-2698 to obtain your original ***Request: Restrict Disclosure of Health Plan/Termination*** form. If the service is related to your dental care, depending on where you were seen for your care, you must contact either University Dentists at 860-679-3170, or Dental Clinic at 860-679-2838 to obtain your original ***Request: Restrict Disclosure of Health Plan/Termination*** form. Completion of your signature and date must be made in the Termination Section of this form, and the form must be mailed back to the applicable billing office at the address listed above. Termination will be the date of your signature on the form. The UConn Health - Health Information Management Department or the applicable Dental area will store the returned form in your medical record as validation of your request to terminate the restriction.

Should termination occur, your insurance company may be billed for the service(s). If your insurance company has requirements that were not followed due to your original request for restriction, (i.e. timely filing, prior authorization and referral requirements, etc.), you will be responsible for any denial of payment from your insurance company, as well as any co-payments, deductibles or other charges for services not covered or paid by insurance or other third party payers.