Request For Access To Protected Health Information

File Number:

You have the right to request to inspect your protected health information in records, which Denti-Cal maintains. You also have the right to request copies of those records. You may be charged for the cost of copying and postage. You will receive a response to your request within 30 days after we receive your request. You will need to send us a photocopy of your California driver's license, Department of Motor Vehicles Identification Card, or other valid identification. You will also need to send documentation verifying your address. Mail this completed form to:

Correspondence Specialist
c/o Delta Dental of California
P.O. Box 15539
Sacramento, CA 95852-1539
800-322-6384

<table>
<tr><th colspan="4">INDIVIDUAL INFORMATION</th></tr>
<tr><td colspan="2">LAST NAME:</td><td>FIRST NAME:</td><td>MIDDLE INITIAL:</td></tr>
<tr><td colspan="2">ADDRESS:</td><td>CITY/STATE:</td><td>ZIP CODE:</td></tr>
<tr><td colspan="2">BENEFICIARY ID NUMBER:</td><td colspan="2">DATE OF BIRTH:</td></tr>
<tr><td>DAYTIME TELEPHONE NUMBER</td><td>EVENING TELEPHONE NUMBER</td><td>EMAIL ADDRESS</td><td>BEST HOURS TO REACH YOU</td></tr>
</table>

Request For Access To Protected Health Information

PROTECTED HEALTH INFORMATION YOU WANT TO ACCESS	
WHAT TYPE OF PROTECTED HEALTH INFORMATION DO YOU WANT TO ACCESS?	
☐ *SUMMARY OF PAYMENTS MADE BY DENTI-CAL (CLAIM DETAIL REPORT)* ☐ TREATMENT AUTHORIZATION REQUESTS	
PLEASE BE SPECIFIC AS YOU MAY BE CHARGED FOR EACH PAGE COPIED.	
FOR WHAT TIME PERIOD DO YOU WANT INFORMATION?	
FROM DATE	TO DATE

METHOD TO ACCESS YOUR PROTECTED HEALTH INFORMATION

☐ PLEASE MAIL ME A COPY OF THE REQUESTED INFORMATION TO THE ADDRESS INDICATED ON PAGE ONE OF THIS FORM.

☐ I WISH TO REVIEW THE REQUESTED INFORMATION IN PERSON.

☐ I REQUEST THAT A PERSON OF MY CHOOSING BE ALLOWED TO INSPECT MY RECORDS.

NAME:
TELEPHONE NUMBER:
ADDRESS: Street Number and Street Name
City, State, Zip

RELATIONSHIP TO YOU:

IF YOU REQUEST TO REVIEW RECORDS IN PERSON YOU WILL BE CONTACTED TO SCHEDULE AN APPOINTMENT.

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IDENTIFYING INFORMATION
☐ COPY OF IDENTIFICATION ATTACHED (PLEASE CHECK TYPE OF IDENTIFICATION) ☐ CA DRIVER'S LICENSE ☐ CA DMV IDENTIFICATION CARD ☐ BIRTH CERTIFICATE ☐ BENEFICIARY IDENTIFICATION CARD ☐ MANAGED CARE CARD ☐ STATE OR FEDERAL EMPLOYEE ID CARD IDENTIFICATION NUMBER:
I UNDERSTAND DENTI-CAL MAY NOT AGREE TO REQUESTED RESTRICTION(S), BUT WILL NOTIFY ME OF ITS RESPONSE TO MY REQUEST. I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT. BENEFICIARY SIGNATURE: DATE:
(IF NO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.) NOTARIZED BY: ON: (DATE) NOTARY PUBLIC NUMBER: UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC
☐ ADDRESS VERIFICATION ATTACHED (PLEASE CHECK OR FILL IN FORM OF ADDRESS VERIFICATION) ☐ UTILITY BILL ☐ PHONE BILL ☐ DRIVER'S LICENSE OTHER

NOTE: ANY ATTEMPT TO FALSELY GAIN ACCESS TO PROTECTED HEALTH INFORMATION IS SUBJECT TO LEGAL PENALTIES.

Denti-Cal is committed to protecting the information you provide us. To prevent unauthorized access or disclosure, to maintain data accuracy, and to ensure the appropriate use of the information, Denti-Cal has in place appropriate physical and managerial procedures to safeguard the information we collect.

Print Form

Reset Form