



Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Patient: \_\_\_\_\_  
Employee: \_\_\_\_\_  
Claim No: \_\_\_\_\_  
Provider: \_\_\_\_\_

Group No: \_\_\_\_\_  
Acct No: \_\_\_\_\_  
Incurred: \_\_\_\_\_  
Charge: \_\_\_\_\_

### **Request for Authorization to Release Medical Information**

We have received a claim for the patient named above. In order to provide you with accurate and timely claim processing, we need your permission to obtain some additional information from your health care providers.

We kindly ask that you complete and return the attached form to HealthComp Administrators at your earliest convenience.

We know that your health benefits are important to you, so we ask that you provide this authorization to us as soon as possible, but no later than forty-five (45) days from the date of our initial request. Otherwise, Federal regulations require that we proceed with issuing a determination on your claim. However, doing so without the requested information would result in the claim being denied or closed. We apologize for any inconvenience this may cause.

If you have any questions please contact our Customer Service Department at (800) 442-7247, option 1.

Please complete and return the attached form to: HealthComp Administrators, P.O. Box 45018, Fresno CA 93718-5018. If you prefer, you may fax the information to us at: (559) 499-2464.

Thank you for your assistance with this matter.

HealthComp Administrators  
Claims Department

**AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH  
INFORMATION**

MEMBER'S NAME: \_\_\_\_\_

MEMBER I.D. NO.: \_\_\_\_\_

I authorize the use and disclosure of my protected health information to HealthComp Administrators so they can determine coverage, perform medical/utilization review, or coordinate benefits with my other health plan or insurer.

My protected health information is individually identifiable health information, including demographic information, collected from me or created or received by a health care provider, a health plan, my employer, or a health care clearinghouse and that relates to: (i) my past, present, or future physical or mental health or condition; (ii) the provision of health care to me; or (iii) the past, present, or future payment for the provision of health care to me.

I understand that if my protected health information is to be received by individuals or organizations that are not health care providers, health care clearinghouses, or health plans subject to federal privacy regulations, my protected health information described above may be re-disclosed and no longer protected by federal privacy regulations. I understand that I may revoke this authorization at any time by sending a written notification to the requesting party, and this revocation will be effective for future uses and disclosures of protected health information.

This authorization expires one year from the date of my signature below.

**SIGNATURE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

If this authorization was signed by a personal representative on behalf of the individual, complete the following:

**PERSONAL REPRESENTATIVE'S NAME:**  
\_\_\_\_\_

**DESCRIPTION OF AUTHORITY:**  
\_\_\_\_\_