South Dakota Farm Bureau Health Plans
1-833-480-2188
sdfbhealthplans.com

REQUEST FOR MEDICAL RECORDS

Attention Provider: Any expense incurred in obtaining medical records is to be paid by the **patient**

Date: _____
Primary Applicant Name:_____ Patient Name:_____
Address_____ DOB_____
City, ST, Zip:_____ County Office:_____

The following medical information is a requirement for children, **Newborn thru 2 months of age**, who are applying for coverage with South Dakota Farm Bureau Health Plans and can be submitted along with submitting health coverage application.

In order for the Medical Underwriting department to process application, please have physician attach the medical information needed as stated below. This may result in the requesting of further medical information to adequately complete underwriting of the application.
NOTE: Medical must be received on or before the last day of the month prior to the requested effective date, or effective date may be adjusted.

Medical information needed: COPY OF MEDICAL RECORDS REGARDING ALL PEDIATRIC VISITS FROM BIRTH TO PRESENT TO INCLUDE THE NEWBORN METABOLIC SCREENING RESULTS, IMMUNIZATION HISTORY OR STATEMENT OF INTENT TO IMMUNIZE

In addition to attaching medical records, any information the physician feels is necessary may be provided in the space below.

_____
_____
_____
_____
_____

_____ _____
Applicant Signature **Date**

_____ _____ _____
Physician Name (Please Print) **Physician Signature** **Date**

Please submit this form and medical to SDFBHP. See attached Patient Authorization for Release of Protected Health Information.

Email: underwritingforms@fbhpservices.com | **Fax:** 931-560-4304

Applicant is encouraged to keep a personal copy of all medical records submitted to SDFBHP. To obtain a copy of medical records from SDFBHP, the applicant must contact the SDFBHP Privacy Office. There will be a charge for the return of medical records.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

This authorization complies with the HIPAA Privacy Regulations

Patient First Name _____ **Patient Last Name** _____

Patient SSN _____ **Patient DOB** _____

Address _____

A. Purpose

This disclosure is at my request for the purposes of underwriting, premium determination, or claims administration or adjudication, including without limitation, appraising Patient's application for health coverage and determining eligibility for enrollment and/or claims payment.

B. Who May Disclose

I hereby authorize the following persons or entities to release health information: (1) licensed health care professionals that have treated or are treating the Patient; (2) allied health care professionals that have treated or are treating the Patient; (3) health care facilities that have treated or are treating the Patient; (4) mental health care facilities and professionals that have treated or are treating the Patient; (5) _____

C. Information to be Disclosed

The information requested pertains to medical information relevant to the Patient's suitability for health coverage or any claim made against such health coverage. This includes any and all information concerning the Patient's medical care, treatment or advice, including medical or other care records, diagnosis & pharmacy information deemed necessary by Farm Bureau Health Plans to issue health coverage or determine the Patient's eligibility for enrollment and/or claims payment. This specifically authorizes the release of information relating to: Substance abuse (including drug and/or alcohol abuse); Mental health (excluding psychotherapy notes); and HIV related information (AIDS related testing or treatment). The Patient/Patient's Representative specifically authorizes the disclosure and release of his/her entire medical record upon request of Farm Bureau Health Plans.

D. Please release the information to the following organizations

Farm Bureau Health Plans
PO Box 313, Columbia TN 38402-0313

E. Right to Refuse

I acknowledge that signing this Authorization is voluntary and I have the right to refuse to sign this Authorization; however, if I refuse to sign this Authorization, I understand that Farm Bureau Health Plans may not be able to gather the information necessary to determine if I am, or an unemancipated minor child is, eligible for coverage by Farm Bureau Health Plans. Further, I understand that I may refuse to sign this Authorization and that a health care provider that is a covered entity may not condition treatment, payment, enrollment in its health plan, or eligibility for benefits on my signing this Authorization.

F. Revocation

I acknowledge that I may revoke this Authorization at any time by sending a written notice to the Farm Bureau Health Plans Privacy Officer at P.O. Box 313, Columbia, TN 38402-0313. However, the revocation will not have any effect on any disclosures that a person or entity may have made in reliance on this Authorization before the revocation was received. Furthermore, I acknowledge that if I revoke this Authorization my application for health coverage may be declined or claims for benefits may be denied.

G. Expiration

I acknowledge that unless I revoke this Authorization, it will remain in effect from the date hereof and continue in effect until the later of 1) a period of one (1) year from the date of execution, or 2) until the application is denied or, 3) if the application is approved, for as long as necessary for any claims to be adjudicated.

H. Redisclosure

I acknowledge that information used or disclosed in accordance with this Authorization may no longer be protected by federal law, and could be redisclosed by the receiving party, but will not be redisclosed by Farm Bureau Health Plans except as authorized by me or as required by law.

I. Certification

I certify that I am (check whichever applies):

☐ the Patient, and the identification that I have provided is true and correct.

☐ the Patient's authorized representative, with authority to consent to treatment and release of information on behalf of the Patient, and the identification that I have provided is true and correct. My relationship to the Patient is that of:_____

Signature: _____ **Signed this _____ day of _____, 20_____.**

SSN: _____ **DOB:** _____

Print Name (Patient / Legal Guardian / Patient Representative): _____