

restrictions form

Member ID number: _____ Member name: _____

Member address: _____

Member telephone: _____ - _____ - _____ Member date of birth: ____ / ____ / ____

I request FCHP to NOT release personal information to:

Name: _____

Address: _____

City, state: _____ ZIP code: _____

Relationship to member: _____

Telephone: _____ - _____ - _____

Valid from date: _____ To date (if applicable): _____

This request applies to:

- Financial information (e.g., premium billing, claims payment, etc.)
- Health care information (e.g., health/illness information, appeals, claims diagnosis)
- Demographic information only (e.g., address changes, etc.)

I may withdraw my authorization at any time by submitting a written request to FCHP's Customer Service Department. If I do, I understand that my personal information may have already been released before I requested this restriction.

Member (or personal representative) signature: _____

Relationship to member (if personal representative): _____

Print name: _____ Date: _____

Mail completed form to:

Fallon Community Health Plan
10 Chestnut St.
Worcester, MA 01608

FOR FCHP USE ONLY

Issued by: _____ Date sent: _____

Date received by privacy clerk: _____

