

Account Number: _____

REQUEST FOR INSURANCE RESTRICTION FORM

Patient Name: _____ Date of Birth: _____ SSN: _____

Address: _____ Phone: _____

HIPAA Omnibus Rule (2013) § 164.522(a)(1)(vi) states a patient may request a restriction on their protected health information (PHI) for their health insurance carrier if the patient elects to pay all of the cost of care out-of-pocket. By completing this form, you are requesting WHS to restrict your protected health information from your health insurance carrier for this date of service: _____

Out-of-Pocket Payment:

I understand that I will pay 100% the cost of the medical care for the date of service referenced above. _____ (initials)

I understand that I will not receive a discount for not processing through my insurance. _____ (initials)

I understand that I cannot submit a claim to my insurance carrier for the date of service above once this form is completed. _____ (initials)

I understand that I cannot request my provider to submit a claim on my behalf for the date of service listed above once this form is completed. _____ (initials)

Restriction request:

I understand that by completing this form and requesting a restriction, that my provider cannot release protected health information for the date of service listed above to my insurance carrier unless this restriction is revoked. _____ (initials)

I understand this restriction is only applicable to my insurance carrier and does not restrict the release of PHI for regular authorized releases of information. _____ (initials)

Compliance with federal insurance plans:

We are prohibited by law to bill and receive cash payment for Medicaid patients. We are required by law to submit protected health information to Medicaid recipients. Medicare patients may refuse to authorize the submission of the bill to Medicare.

Downstream entity:

I understand this restriction is only applicable for Women's Health Specialists and does not cover restriction made for laboratory/pathology testing or prescriptions submitted to a pharmacy on behalf of the patient for the date of service above or any other provider referral. _____ (initials)

I understand it is my responsibility to notify other medical entities who are involved in my care that I request such a restriction and to make necessary arrangements. _____ (initials)

Signature of Patient or Representative

Date