Group Insurance Trust of the
California Society of Certified Public Accountants
Request for Accounting of Disclosures

Please provide the information below. We cannot respond to your request without this information.

Your name: _____

Employee's name: _____ Employee's ID: _____

Use this form to request an accounting of certain disclosures of your health information maintained by the Health Plans and used to make decisions about your Health Plan benefits. Please note that this accounting will not include:

1. Disclosure of your information in the regular course of Health Plan administration and operations or for payment purposes.
2. Disclosures we make to you or your personal representative.
3. Disclosures made pursuant to your written authorization.
4. Disclosures to friends or family members made in your presence.
5. Disclosures made in an emergency situation.
6. Disclosures for national security reasons or to a law enforcement officer or institution for health or safety reasons while you are in custody.

In addition, **your accounting will not include disclosures made prior to April 14, 2003**.

You must specify the time period for which you would like an accounting (not to exceed six years from the request date). Be sure to provide your address below. Your accounting will be mailed to that address. **[optional e-mail]**

Provide and accounting for the period starting _____ and ending _____ (not to exceed six years).

Apply this request to the following Health Plans:

- ❑ CalCPA Health Medical Plans (PPO)
- ❑ Anthem Blue Cross Medical Plan (HMO)
- ❑ Vision Service Plan (Vision Plan)
- ❑ Delta Dental (Dental Plan)
- ❑ Other

You are entitled to one free accounting for a 12-month period. If you make a second request within a 12-month period, you may be charged a fee for the cost of creating the accounting. You will be notified in advance of any such charges.

For internal use only:

- ❑ Approved Notice of extension sent: _____
- ❑ Denied Date received: _____ Response Date: _____

Policy Attachment _____ 10452739

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I hereby request an accounting of Health Plan disclosures of my health information, as described above. If I have already requested an accounting within the last 12-months, I understand that I may be charged for the cost of creating the accounting.

_____ _____

Signature* Date

**If you are making this request on behalf of another individual, a completed Personal Representative Form must be on file with the Health Plans unless you are the individual's parent or guardian and you are also a participant in a Health Plan.*

Please provide the address where the written accounting should be sent:

_____

_____

_____

_____

Send this completed request form to:

Banyan Administrators, LLC
Managers for the CalCPA Health Programs
1215 Manor Drive, Suite 200
Mechanicsburg, PA 17055
Fax – (877) 237-4519
calcpahealth@fnrm.com

If you have questions about this form or your right to request to inspect or receive copies of your health information, contact Banyan Administrators, LLC at (877) 480-7923.