Privacy Complaint Filing Form

This form is used for you to file a complaint with your health plan about its privacy practices, or its compliance with its Notice of Privacy Practices, Privacy Policies and Procedures, or federal or state privacy laws. Questions regarding this form should be directed to the Member Services Department at the number located on the back of your member identification (ID) card**.**

Member Information: Include any letters in front of the identification number on the member ID card of the individual whose information will be released.

Name: (First, Middle, Last, Title)	**Date of Birth:** (Month/Day/Year)
Address: (including zip code)	
Home Telephone Number: (including area code)	**Work Telephone Number:** (including area code)
Social Security Number:	**Member ID Number:**

Provide a statement of your complaint.

Provide a statement of the resolution you are seeking.

Approval: (You OR your personal representative must sign and date this form in order for it to be complete.)

Member Signature:	**Personal Representative Information:** A Personal Representative is a person who has the legal authority to act on behalf of an individual. A copy of a Power of Attorney or other court-related legal document must be on file at the health plan.
(Signature of Member) (Date)	(Printed Name of Personal Representative) (Date) (Telephone Number) (Signature of Personal Representative) (Description of representative's authority)

To: ______________________
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Information About Filing a Privacy Complaint

- You, or your Personal Representative on your behalf, have the right to file a complaint to your health plan about its privacy practices, or its compliance with its Notice of Privacy Practices, Privacy Policies and Procedure, or Federal or State privacy laws.

- Your health plan will **not** require you to waive any right you may have under federal or state privacy or other laws as a condition of filing your complaint, nor will filing your complaint adversely affect your enrollment in, your eligibility for benefits, or our payment of your claims under your health plan.

- To assist your health plan in investigating this complaint, please complete this form by printing or typing into the spaces provided, or by or sending a written summary of your complaint. Attach additional pages if necessary to make your request clear.

- Return form to:

  InterCounty Hospitalization Plan
  720 Blair Mill Road
  Horsham, PA 19044
  Attn: Privacy Official