Restriction Request Form

Use this form to request restrictions on FirstCare Health Plans use or disclosure of your Protected Health Information (PHI) for payment or health care operations purposes. You may also use this form to terminate a previously granted request for restriction.

PLEASE NOTE: DO NOT USE THIS FORM TO SIMPLY CHANGE YOUR ADDRESS.

If you need assistance in completing this form, or with a change of address, please call the Customer Service number listed on the back of your Member Identification Card.

WHEN COMPLETED AND SIGNED PLEASE MAIL TO: **FirstCare Health Plans**
12940 N HWY 183
Austin, TX 78750

Section A: Restriction Request or Termination

Is this form being used to terminate a previously approved request for Restriction? If "Yes", complete Section B, then proceed to Section D. If "No", then complete the form entirely.

☐ **Yes –** Enter date to terminate previous request: _____
☐ **No** **Date: month/day/year**

Section B: The individual for whom restriction is being requested. Please complete the following:

Name | **Group #** | **Identification\Subscriber #**

Social Security Number | **Date of Birth**

Address | **City** | **State** | **ZIP**

Area Code & Telephone Number | **E-mail address (if available)**

Section C: Please specify your Protected Health Information (PHI) that you want restricted:

Please state how you would like to restrict the use and disclosure of this information:

Please indicate if this restriction request should apply to communicating your PHI to your Health Savings Account (HSA) or Flexible Savings Account (FSA), if applicable:

☐ **Yes** ☐ **No**

If this request is granted, please note the following:

1. **The request will only apply to your current Group and Subscriber Numbers and benefits coverage. If your Group or Subscriber Numbers change, or your benefits coverage changes (i.e., dental coverage is added), you must submit a new Restriction Request for the new group/subscriber number or benefit coverage.**
2. **This request will expire eighteen (18) months after your benefits coverage has terminated.**
3. **FirstCare Health Plans and its Business Associates are only responsible for the PHI that they release in accordance with your designation in Section C.**

Section D: Signature - This document must be signed by the individual, parent of minor child or the individual's Personal Representative.

I request that FirstCare Health Plans restrict the use or disclosure of my PHI as specified in Section C above. I understand that FirstCare Health Plans is under no obligation to agree to my request. I understand I will receive a written determination regarding my request. I understand that if I am signing on behalf of a minor child, this request will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

Signature **Date: month/day/year**

Section E: If Section D is signed by a Personal Representative, please complete the information below:

If you are signing as a Power of Attorney, Legal Guardian, Executor, or Administrator, attach a copy of the Legal documents. You do **NOT** have to attach copies of these documents if they are already on file with FirstCare Health Plans.

Personal Representative's Name **Relationship to Individual**

Personal Representative's Address **City** **State** **ZIP**

Personal Representative's Area Code & Telephone Number **Personal Representative's E-mail address (if available)**