GEHA

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HIPAA COMPLAINT FORM

This form is for use in reporting any HIPAA concerns to GEHA's Privacy Office.

About You

Plan ID Number: _____

Your Name: _____ **Date of Birth:** _____

Address: _____

Telephone Number: _____

Please place a check mark in front of each plan you want this Access request to be applied:

- ☐ GEHA Health Plan
- ☐ Connection Dental *Plus* Plan
- ☐ GEHA Connection Dental Federal Plan
- ☐ CONNECTION Vision Plan

Whose Information Is Your Complaint Regarding

Subscriber Name (if known): _____

Address (if known): _____

Subscriber ID Number (if known): _____ **Telephone Number (if known):** (_____) _____

Patient Name (if known): _____ **Date of Birth (if known):** _____

Please select the applicable Plan below, if known:

- ☐ GEHA Health Plan
- ☐ Connection Dental *Plus* Plan
- ☐ GEHA Connection Dental Federal Plan
- ☐ CONNECTION Vision Plan

What Is Your Concern

Name of GEHA employee involved (if known): _____

Brief description of the event. Please give all the dates and other details that you can remember.

_____

_____

_____

_____

_____

Date: _____

Patient or Legal Representative Signature: _____

Relationship to patient: _____
(i.e. parent, legal guardian, power of attorney, etc.)

PHI03/R9
ENR-1705-PHI03
GE-FRM-0119-008

PLEASE RETAIN A COPY FOR YOUR RECORDS AND RETURN THE ORIGINAL SIGNED COMPLAINT FORM TO:

ATTN: Privacy Officer
GEHA
P.O. Box 21542
Eagan, MN 55121
FAX: 816-257-3283