KANSAS FARM BUREAU® Health Plans

REQUEST FOR MEDICAL RECORDS

Kansas Farm Bureau Health Plans
1-833-282-5928
kfbhealthplans.com

Attention Provider: Any expense incurred in obtaining medical records is to be paid by the **patient**.

Date: ___________________
Primary Applicant Name: _________________________
Address: _______________________________________
City, ST, Zip: _____________________________________

Patient Name:_________________________
DOB: _________________________________
County Office: _________________________

The following medical information is a requirement for children, **3 months thru 25 months of age**, who are applying for coverage with Farm Bureau Health Plans and can be submitted along with submitting health coverage application.

This information submitted may result in the Farm Bureau Health Plans Medical Underwriting department requesting further medical information to adequately underwrite your application. Prompt return of **all** information requested below is necessary to complete the underwriting procedure.

Medical information needed: COPY OF MEDICAL RECORDS REGARDING ALL PEDIATRIC VISITS FROM BIRTH TO PRESENT TO INCLUDE IMMUNIZATION HISTORY

Diagnosis, condition or problem: ____ Date of onset:_______________________________

What type of treatment did he/she receive? Please explain: ____

____

List any medication(s) taken:____

Are they currently receiving treatment or taking medication? ☐ **Yes** ☐ **No**

If "Yes," is condition controlled with treatment or medication? ☐ **Yes** ☐ **No**

If "No," what is the stop date of treatment or medication? _____________________________ Is recovery complete? ☐ **Yes** ☐ **No**

What is current status or prognosis? ____

____ _________________________
Applicant Signature **Date**

____ ____ _________________________
Physician Name (Please Print) **Physician Signature** **Date**

Please submit this form and medical records to KFBHP. See attached HIPAA Authorization Form.

Email: underwritingforms@kfbhp.com | **Fax:** 931-560-4293

Applicant is encouraged to keep a personal copy of all medical records submitted to KFBHP. To obtain a copy of medical records from KFBHP, the applicant must contact the KFBHP Privacy Office. There will be a charge for the return of medical records.

HIPAA Authorization

Plan Type ____________________

Applicant Name ____________________

SSN ____________________ DOB ____________________

Address ____________________

City ____________________ State ____________ Zip ____________

I hereby authorize the use or disclosure of protected health information ("PHI") about me as described below:

1. I authorize Kansas Farm Bureau Health Plans ("KFBHP") to use **the PHI I have provided on the application form to determine my initial and continued eligibility to obtain coverage under the health and/or dental coverage for which I have applied, to determine the rates and terms which apply to the plan.**

2. The following group of persons employed or working for KFBHP may use or disclose my PHI, which is described above: **Employees involved in accounting, review of medical records and membership services processes**.

3. The information which is disclosed by KFBHP shall be disclosed only to **______________________**, and solely for the limited purposes identified in this authorization.

4. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by KFBHP in reliance on this authorization, by sending a written revocation to: **KFBHP, Attn: Privacy Office, P.O. Box 1424, Columbia, TN 38402-1424; Fax: 931-388-8326.**

5. This authorization will expire one hundred eighty (180) days *after* I have dis-enrolled from or become ineligible to participate in this health and/or dental coverage.

6. I understand that the information which will be provided under this authorization is necessary for KFBHP to fulfill its obligation to provide health and/or dental coverage to members of KFBHP and that KFBHP will condition enrollment and eligibility in the health and/or dental benefits plan/policy on my providing this authorization, and my application may be denied and/or eligibility revoked, if I refuse to provide this authorization or revoke this authorization.

7. I understand that if the person or entity that receives my PHI is not a health care provider or a health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by federal privacy regulation***. I have been advised, however, that KFBHP and The Kansas Farm Bureau have entered into a confidentiality agreement with regard to any PHI used or disclosed by KFBHP to The Kansas Farm Bureau for the purpose defined above.***

______________________________ ______________________________ ______________

Applicant Name (or Legal Representative) Signature Date