REQUEST TO RESTRICT PROTECTED HEALTH INFORMATION TO HEALTH PLAN

By signing this form, I understand and agree that:

- I am requesting that Gundersen St. Joseph Hospital and Clinics not disclose my protected health information (PHI) to my health plan or third-party insurance carrier for the indicated service(s) below.
- I have read through and understand my Rights to Restrict Protected Health Information to a Health Plan *(page 2)*.
- The records of the restricted services/items listed below will not be released or billed to my health plan for the purposes of payment or health care operations.
- I am financially responsible for these restricted services/items and expect to pay out-of- pocket, in full, at the time of service for Gundersen St. Joseph Hospital and Clinics to accept this restriction request.
- I acknowledge that I am aware of possible disclosure to my health plan prior to the completion of this form if such requirements such as prior authorization were requested/completed.

Date of Service(s): / to /

Servicing Provider: _____

Description of Services/Items to be restricted: _____

Health Plan for which information is being restricted: _____

Total Charge (or estimated) Amount Due: $ _____

(I understand that I am responsible for any additional charges not included in the estimate for this service)

ATTENTION: Gundersen St. Joseph Hospital and Clinics may terminate this restriction by notifying you in writing if you fail to pay in full.

Signature: _____ Date: _____

If signed by someone other than the patient: ☐ Parent, Legal Representative ☐ Health Care Agent (Health Care Power of Attorney)

Termination of Request

☐ I am requesting termination of restricted disclosure for the above services.

Signature: _____ Date: _____

If signed by someone other than the patient: ☐ Parent, Legal Representative ☐ Health Care Agent (Health Care Power of Attorney)

When Complete, send form to Gundersen St. Joseph Hospital and Clinics Customer Financial Services at:

Fax: 608-775-2795

Email: revenuecycle-billing-inbox@emplifyhealth.org

****

FOR SUPERVISOR USE ONLY:

Position Title of Reviewer(s):_____ Reviewed Date:_____

Request above is: ☐ Approved ☐ Denied

Reason for Denial:

☐ *Payment in full not obtained* ☐ *Disclosure required by law (patient has Medicaid)* ☐ *Unable to unbundle services* ☐ *Other*_____

Supervisor Signature _____ Date: _____

DATE COPY OF FORM MAILED TO PATIENT FOR APPROVAL/DENIAL: _____

****

FOR INTERNAL USE ONLY:

If approved, send original to Privacy Office, Mailstop: NCA1-09

Privacy Office will scan into patient's medical records under doc type: Self-Pay Disclosure Restriction and add the FYI "Release Restriction".

PATIENT RIGHT TO RESTRICT PROTECTED HEALTH INFORMATION TO HEALTH PLAN

You have the right to request restrictions on whether Gundersen St. Joseph Hospital and Clinics discloses (shares) your protected health information (PHI) with your health plan.

PATIENT RIGHTS AND RESPONSIBILITIES WITH RESPECT TO THIS REQUEST:

- Receiving a Copy of this Request: You may request a copy of their completed **"Request to Restrict Protected Health Information to a Health Plan"** at any time.
- Refusal to Sign this Request: You are under no obligation to sign this form. The health plan for which disclosure is being restricted may not condition treatment, payment, enrollment in a health plan or eligibility for the health care benefits on the decision to sign this request.
- Restricted Disclosure from non Gundersen St. Joseph Hospital and Clinics Providers: Gundersen St. Joseph Hospital and Clinics will not share restricted PHI with your health plan but will continue to share information with your providers. You are responsible for notifying all providers outside of Gundersen St. Joseph Hospital and Clinics not to disclose these services to your health plan.
- Disclosure for Subsequent Services: In the event that previously restricted PHI is required to satisfy your health plan's requirement for medical necessity, prior authorization, or payment of a subsequent service, and that subsequent service has not been restricted and paid for by you, Gundersen St. Joseph Hospital and Clinics is permitted to disclose such information. Therefore, if any of the previously restricted PHI would be part of a follow up visit at Gundersen St. Joseph Hospital and Clinics, you need to ask for the restriction again for that follow up visit. This would include the need to request the restriction for any related laboratory or radiology service if the restriction applies to those ancillary services as part of your visit.
- Termination of this Request: In order to terminate a previous request, you must contact Gundersen St. Joseph Hospital and Clinics Customer Financial Services 608-775-8660 to obtain your original Request: **"Request to Restrict Protected Health Information to a Health Plan"** form.
    - Should termination occur, your health plan may be billed for the service(s).
    - If your health plan has requirements that were not followed due to your original request for restriction, (i.e. timely filing, prior authorization and referral requirements, etc.), you will be responsible for any denial of payment from your health plan, as well as any co-payments, deductibles or other charges for services not covered or paid by insurance or other third-party payers.
- Payment for Care: Patient will be responsible for the full cost of care and no self-pay discount will be applied.

Gundersen St. Joseph Hospital and Clinics RIGHTS AND RESPONSIBILITIES WITH RESPECT TO THIS REQUEST:

Gundersen St. Joseph Hospital and Clinics is only required to honor your request not to disclose PHI to your health plan when:

- You have completed and signed the **"Request to Restrict Protected Health Information to a Health Plan".**
- The information is not required to be disclosed to your health plan to comply with federal or state law.
- At the time of service, you shall pay out of pocket in full the estimated cost of the service(s).
    - If payment doesn't cover the full cost of service(s), you shall pay the remaining balance within 30 days of receipt of the bill for the service(s).

Gundersen St. Joseph Hospital and Clinics is not required to honor your request when:

- You do not pay in full, as outlined above. We will terminate your request for the restriction and notify you of this termination via a letter. Termination will occur 30 days after the date of the letter. We will then pursue payment from your health plan. A copy of the letter will be stored in your medical record as validation of our termination of your original requested restriction, or
- You request that the restriction be terminated.