HIPAA PRIVACY COMPLAINT FORM

Purpose: This form is for the use by a TRICARE beneficiary to submit an inquiry or complaint about TRICARE or TriWest HIPAA Privacy policies or practices.

SECTION A: Individual Submitting Inquiry or Complaint

Name:			
Address:			
Telephone:	( )		E-mail:
Social Security Number:	Sponsor: - -		Beneficiary: - -

TO THE BENEFICIARY: PLEASE READ THE FOLLOWING AND PROVIDE THE REQUESTED INFORMATION

You have the right to file a privacy complaint with TriWest (your TRICARE contractor), with the TRICARE Management Activity (TMA) Privacy Official, with the Military Treatment Facility Privacy Official, or with the Secretary of the Department of Health and Human Services (DHHS). You do not need to notify us or TMA prior to filing a complaint with DHHS. You may use this form to file a complaint about any and all issues relating to the privacy practices of TriWest. The practices include the use and disclosure of protected health information, denial of access, and the denial of right to amend those records we have in our possession which pertain to you.

For TriWest related inquiries or complaints, TriWest will research your complaint and respond with the results of TriWest's evaluation plan or the action taken to resolve the conditions noted in your complaint.

SECTION B: DESCRIPTION OF COMPLAINT

Please select one: ❑ **Inquiry** ❑ **Complaint**

Please provide a concise statement of your inquiry or complaint.

What resolution do you seek from submitting your inquiry or complaint?

I certify that the statements made in this inquiry or complaint are true and correct to the best of my knowledge.

BENEFICIARY'S SIGNATURE: **Date** ____/__/____

If submitted by a personal representative on behalf of the beneficiary, complete the following:

Personal Representative's Name:

Relationship to Beneficiary:

YOU ARE ENTITLED TO A COPY OF THIS COMPLAINT

Please submit the completed and signed request to: TriWest Healthcare Alliance; Attn: HIPAA Privacy Official; P.O. Box 42049; Phoenix, AZ 85080-2040