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

**Name:** _____

**Address:** _____

**Contact telephone number during business hours:** _____

## 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
- ☐ GEHA Connection Dental Federal Plan
- ☐ Connection Dental *Plus* 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:** _____

**Signature:** _____

**Relationship (if not patient):** _____

**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**