

## CONTRACT REQUEST FORM

Certified Mail # \_\_\_\_\_ or Hand Delivery (Date & Name) \_\_\_\_\_

To: HMO Membership Services \_\_\_\_\_ (HMO Name)

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

cc: \_\_\_\_\_ (Others)

### Patient Contract Request Statement

This is my formal request that the HMO send me a copy of all documents constituting the agreements between me and my HMO and between my HMO and my HMO medical group. My request includes, but is not limited to, amendments and all supporting documents, which are incorporated by reference into the contracts or implied. If you cannot or will not respond fully and completely to my request, please inform me of your reasons in writing, within **ten (10) working days** of receipt of this request.

I request that you provide a cover letter which lists the titles of all documents pertaining to my request for production. Should any document(s) be unavailable, please identify the document(s) by name in the cover letter. Specify a date by which the HMO will comply or, alternatively, provide legal citations as justification for refusal, in part or in full.

### Patient Rights Statement

Patients have the legal right to participate in their healthcare. This includes the right to be fully informed regarding the terms and conditions of HMO contracts governing their healthcare. Denial of access to legal documents governing my healthcare violates my rights.

### Patient Responsibility Statement

My HMO states that patients must accept responsibility for actively participating in medical decision-making. By taking responsibility, I require that my HMO and any other person or entity that affects my healthcare recognize and enforce my rights.

### Patient Satisfaction Request and Self-Protection Plan

Please comply with my request no later than **10 working days** after receipt of this correspondence. Should you be uncooperative in satisfactorily complying with my request, I will enforce my healthcare rights. Please include this document as part of my Official Medical Record.

_____ Patient Name (Print)	_____ Agent Name (Print)	_____ HMO Patient I.D. #
_____ Patient Signature	<u>or</u> _____ Agent Signature	_____ Date (_____) _____ Telephone #