UnitedHealthcare
MILITARY & VETERANS

PRIVACY INQUIRY/COMPLAINT FORM
TRICARE WEST REGION

PURPOSE
This Privacy Inquiry Complaint form is for use by the TRICARE beneficiary or beneficiary's authorized representative to submit an inquiry or complaint about UnitedHealthcare privacy policies or practices.

Your PHI is protected by the Privacy Act, the DoD Privacy Program, the Health Insurance Portability and Accountability Act (HIPAA), state laws, and UnitedHealthcare policies and procedures. The employees of UnitedHealthcare are trained to protect your information.

Please mail the completed and signed form to the following address:
UNITEDHEALTHCARE MILITARY & VETERANS
TRICARE WEST PRIVACY OFFICE
PO BOX 105661
ATLANTA GA 30348-5661

or

You may fax your completed and signed form to:
1-877-894-1493

Privacy Act Statement

This statement serves to inform you of the purpose for collecting personal information required by the UnitedHealthcare Military & Veterans Information System and how it will be used.

AUTHORITY: 10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR Part 199, Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); and E.O. 9397 (SSN), as amended.

PURPOSE: To collect information from you in order to manage your TRICARE enrollment, provide your benefits, and/or pay for those services.

ROUTINE USES: Your records may be disclosed to investigate waste, fraud, abuse, security, and privacy concerns. Use and disclosure of your records outside of DoD may also occur in accordance with the DoD Blanket Routine Uses published at http://dpclo.defense.gov/Privacy/SORNsIndex/BlanketRoutineUses.aspx and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)).

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

DISCLOSURE: Voluntary. If you choose not to provide your information, no penalty may be imposed, but absence of the requested information may result in administrative delays or the inability to process your request.

UnitedHealthcare MILITARY & VETERANS

PRIVACY INQUIRY/COMPLAINT FORM

Purpose: This form is for use by the TRICARE beneficiary or beneficiary's authorized representative to submit an inquiry or complaint about UnitedHealthcare privacy policies or practices.			
SECTION A: Individual Submitting Inquiry or Complaint			
Name:			
Address:			
Telephone:	( )		Email:
Social Security Number Or DoD Benefits Number:	Sponsor:	Beneficiary:	
TO THE BENEFICIARY: Please read the following and complete the information requested.			
You have the right to file a privacy complaint with UnitedHealthcare (your TRICARE contractor), with the Defense Health Agency (DHA) Privacy Official, with the Military Treatment Facility (MTF) Privacy Official, or with the Secretary of the Department of Health and Human Services (DHHS). You do not need to notify us or DHA 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 UnitedHealthcare, including the use and disclosure of protected health information (PHI), denial of access to PHI and the denial of a request to amend records.			
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 in 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. **SIGNATURE:** **Date: ____/____ /_____**			
If submitted by a personal representative on behalf of the beneficiary, complete the following:			
Personal Representative's Name:			
Relationship to Beneficiary:			

Please submit the completed and signed request to:
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TRICARE WEST PRIVACY OFFICE
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ATLANTA GA 30348-5661
FAX: 1-877-894-1493