AIU Domestic Claims
Accident & Health
PO 25987
Shawnee Mission, KS 66225
(800) 551-0824
(866) 893-5984 (Fax)

INDIA NETWORK HEALTH INSURANCE
REQUEST FOR PROTECTED HEALTH INFORMATION

Client Name:	
A&H Member Name/ Member Number:	
Policy Number:	
Date(s) of Service:	

Request By:	☐ Client	
	☐ Legally Authorized Representative	
	☐ Other	
	Name:	
	Relationship To Client:	
	Contact Information	
	☐ Mailing Address:	
	City:	State:
	☐ Telephone: ( ) -	☐ Fax: ( ) -
	☐ E-Mail:	

Purpose(s):	☐ Claim Status
	☐ Amendment (Specify in writing on separate sheet)
	☐ Other (Specify in writing on separate sheet)

Information Requested:	☐ Claim Status
	☐ Diagnosis
	☐ Other / Specify:

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal law.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or on_____.

Signature of Client or Client's Legally Authorized Representative	Date
Print Client's Name or Name of Client's Legally Authorized Representative	Relationship to Client
Signature of Requesting Individual	Date
Print Name of Requesting Individual	Relationship to Client

This Form must be signed by the Client or Client's Legally Authorized Representative and the Requesting Individual. Please fax this completed form to: 866-893-5984