

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

**India Network Health Insurance
 REQUEST FOR PROTECTED HEALTH INFORMATION**

Insured (Client) Name:	
Insured Primary ID:	
Policy Number:	
Date(s) of Service:	

Request By:	<input type="checkbox"/> Client	
	<input type="checkbox"/> Legally Authorized Representative	
	<input type="checkbox"/> Other	
	Name:	
	Relationship To Client:	
	Contact Information	
	<input type="checkbox"/> Mailing Address:	
	City:	State:
	<input type="checkbox"/> Telephone: () -	<input type="checkbox"/> Fax: () -
	<input type="checkbox"/> E-Mail:	

Purpose(s):	<input type="checkbox"/> Claim Status
	<input type="checkbox"/> Amendment (Specify in writing on separate sheet)
	<input type="checkbox"/> Other (Specify in writing on separate sheet)

Information Requested:	<input type="checkbox"/> Claim Status
	<input type="checkbox"/> Diagnosis
	<input type="checkbox"/> 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