Individual and Family Plans

Plan Change Request

PROVIDENCE Health Plan

Instructions and Information

- You may change your Providence Individual & Family Plan during our annual renewal. To change your current plan, you must complete and submit this form by fax or mail. We must receive your form **by Nov. 30, 2009.**
- You automatically qualify for any plan with equal to or reduced benefits from your current plan. See the Plan Crosswalk below. However, changing to a plan with increased benefits is subject to Providence Health Plan's review and approval. Your previously submitted health statement and recent claims information will be used to evaluate your request.
- You must **complete the Health Status Verification** on page 2 of this form.
- Fax or mail completed form to **503-574-5772** or **Providence Health Plan, P.O. Box 4649, Portland, OR 97208-4649**
- If we approve your request, the effective date of the plan change will be the first of the month following receipt of this form.

Plan Crosswalk

If you belong to the plan in this column…	you automatically qualify for one of the plans marked with a "•" in the same row without review.												
	Optimum 500	**Optimum 1000**	**Optimum 2500**	**Optimum 5000**	**Optimum 10000**	**Value 500**	**Value 1000**	**Value 2500**	**Value 5000**	**Value 7500**	**Prime 10000** (new plan)	**HSA 2500**	**HSA 3500** (new plan)
Optimum 500		•	•	•	•	•	•	•	•	•	•	•	•
Optimum 1000			•	•	•		•	•	•	•	•	•	•
Optimum 2500				•	•			•	•	•	•	•	•
Optimum 5000					•				•	•	•	•	•
Optimum 10000									•	•	•	•	•
Value 500		•	•	•	•		•	•	•	•	•	•	•
Value 1000			•	•	•			•	•	•	•	•	•
Value 2500				•	•				•	•	•	•	•
Value 5000					•					•	•	•	•
Value 7500					•						•	•	•
HSA 1200 (discontinued as of 11/1/09)			•	•	•			•	•	•	•	•	•
HSA 2500			•	•	•			•	•	•	•		•

Step 1: **Verify your information**

Please enter policy holder information (The policy holder is the person who holds the Individual contract)

Policy holder Name			Policy holder member I.D. number
Mailing Address 1			Address 2
City	State	Zip Code	County
Home Phone Number	Work Phone/Other Phone Number	E-mail Address	

Step 2: **Select your new plan choice**

Optimum Plans	Value Plans	Prime Plan	HSA Plans
❑ Optimum 500	❑ Value 500	❑ Prime 10000	❑ HSA 2500
❑ Optimum 1000	❑ Value 1000		❑ HSA 3500
❑ Optimum 2500	❑ Value 2500		
❑ Optimum 5000	❑ Value 5000		
❑ Optimum 10000	❑ Value 7500		

Step 3: **Health Status Verification**

Have you or any of your dependents who are requesting a change in coverage had any medical advice, diagnosis, care, or treatment, including prescribed medications, recommended or received from a licensed health care professional or had any illness, ailment, injury, health problem, symptoms, physical impairment, surgery or hospital confinement since enrolling with Providence Health Plan?

- ☐ No
- ☐ Yes, as described below:

Member Name, Health Status Event, Date of Event, Name of Provider or Facility

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Step 4: Read the **Certification and Authorization**

Certification Statement

I affirm that I am requesting a change in coverage for myself and my enrolled family dependents and that the answers given in this Change Plan Form are complete and correct. I am providing these answers as part of the procedure required by Providence Health Plan (PHP) to request a change in my insurance coverage. **I understand that it is my responsibility to notify PHP of any changes in my or my dependent's previously submitted health statement(s)**. If I fail to disclose this information to PHP, if this request contains any material misstatements or omissions, PHP may, within the first two years of coverage, deny coverage, modify or cancel the contract, and/or take any other legal action available to it by law. **I will promptly inform PHP in writing if anything happens before my coverage takes effect that makes this change request incomplete or incorrect.** I understand and agree that no change in coverage shall be in force until the effective date determined by PHP and that PHP may contact me to clarify this request. As the policyholder, I understand I have the right to inspect the information in my file.

Authorization for the Release and Use and Disclosure of Personal Health Information

I authorize any physician, healthcare provider, hospital, insurance or reinsurance company, or other insurance information exchange service to disclose to Providence Health Plan (PHP) or its representatives personal health information relating to me and/or any family members included in this Plan Change Form. Furthermore, I agree to sign any additional forms related to release of personal health information, as needed by PHP to obtain this information. I acknowledge and understand that the health information released to PHP:

- Will only be used for the purpose of determining enrollment in health plan coverage or eligibility for benefits;
- May include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, medication records, dental records, or hospital records (including nursing records and progress notes); and
- May address all medical and mental health conditions and services, including HIV treatment, but shall exclude psychotherapy notes and genetic information.

I understand that I may cancel this authorization at any time by sending a written request to PHP. My cancellation of this authorization will not affect any action PHP took before it received my request. If I do not revoke this authorization, it will automatically expire upon termination of my coverage with PHP. I understand that if I choose not to sign this authorization that PHP will be unable to process my request for change in coverage.

In addition, if I understand that PHP may request and disclose personal health information, other than psychotherapy notes, for the purpose of: (a) performing the health plan business operations of PHP; (b) facilitating health care treatment; (c) issuing or facilitating payment for health care services; or (d) as required by law. The disclosure of psychotherapy notes by PHP is restricted to circumstances in which the patient has provided a signed authorization.

For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Notice of Privacy Practices. A copy is available at our Internet site at **www.providence.org/healthplans** or by calling Customer Service.

Step 5: **Sign and Submit**

Acceptance of plan change procedure

1. I understand that Providence Health Plan will notify me in writing as to the status of my change request.
2. I am the policyholder, and am requesting this change for myself and my enrolled family dependents.

4. By signing, I agree to the above conditions.

Signature of Policyholder X ____	Date

Please fax or mail your completed Plan Change Request by Nov. 30, 2009 to:

503-574-5772 or Providence Health Plan, P.O. Box 4649, Portland, OR 97208-4649