GEHA®

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PRIVACY COMPLAINT FORM

This form is for use in reporting any privacy or HIPAA compliance concerns to GEHA's Privacy Office.

About You

Name: _____

Address: _____

Phone Number: (_____) _____ **Email:** _____

Whose Information Is Your Complaint Regarding

Name of Impacted Individual: _____

Address : _____

If the complaint involves a GEHA member, please give plan information:

Plan ID Number: _____

Member Name: _____ **Member Date of Birth :** _____

Please select the applicable Plan below, if known:

☐ Health Plan ☐ Dental Plan ☐ Vision Plan

What Is Your Concern

Name of GEHA employee involved (if known): _____

Brief description of your concerns. Please give all the dates and other details that you can remember. Please attach pages if additional space is needed.

_____

_____

_____

_____

_____

Date: _____

Signature: _____

Relationship (if not impacted individual): _____

PLEASE RETAIN A COPY FOR YOUR RECORDS AND RETURN THE ORIGINAL SIGNED COMPLAINT FORM TO:

ATTN: Privacy Officer
GEHA
P.O. Box 21542
Eagan, MN 55121
FAX: 816-257-3283