TUFTS Health Plan

Berklee college of music

Medical / Prescription Claims Profile Request Form

Please Note: All fields are required. Incomplete or incorrect forms will be returned.

Type of Profile Request: (check all that apply)
Medical ☑ Date Range of Data Requested: 09/ 01 /2013 to 08/ 31 /2014
Prescription (PCS) ☑ Date Range of Data Requested: 09/ 01 /2013 to 08/ 31 /2014

Member / Legal Representative Information: *(one form per member)*

Member Name *(please print)*: _____

Member 11 digit ID Number:
(found on Member's Tufts HP ID card) ☐☐☐☐☐☐☐☐☐☐☐

Member Date of Birth: ____/____/____ *(month/day/year)*

Member or Legal Representative* Signature: _____ Date: _____
(must be over 18 years of age)

If applicable:
Legal Representative Name *(please print)*: _____

Legal Representative Relationship to Member: *(please check one)*
Spouse ☐ Parent ☐ Guardian ☐
Other ☐ *Please specify* _____

*A Legal Representative is defined as a parent of a minor child, a legal guardian, a person acting in *loco parentis* (in place of parent) of a minor child or any other person with legally granted authority, such as a Health Care Proxy or Durable Power of Attorney or Power of Attorney. To be recognized as a legal representative (other than a parent of minor child) by Tufts Health Plan, a separate authorization form must be completed and on file with us before this request can be completed.

I represent that the signature above is my own or that I have been legally authorized to affix the signature. I recognize that signing the name of another person to this document without legal authorization may be subject to prosecution. Signature requirements are intended to protect member privacy.

Claim profiles could contain sensitive medical information (such as the diagnosis, testing and/ or treatment of HIV/AIDs, substance abuse, genetic testing and/or venereal diseases) unless otherwise directed to omit such data. Tufts Health Plan reserves the right, in accordance with applicable law, to delete certain highly sensitive, medical claims/information from profiles.

Contact Information:

Member/ Legal Representative Daytime Phone Number: ( )

Please mail Claim Profile Report(s) to the address below:

_____

_____

_____

Return completed form by mail or fax.

Tufts Health Plan; Member Services, 705 Mt. Auburn Street, P.O. Box 9170, Watertown, MA 02471-9170

Tufts Health Plan fax number: (617) 673-0661

For internal use only:
Rep Name & Ext.:_____ SMS Init:_____ Admin Spvr Init:_____ Date Completed:_____

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