

HIPAA COMPLAINT FORM

Use this form to file a complaint about possible violations of your privacy and security rights, including your rights under the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA).

You may submit your request by addressing it to the **Chief Compliance and Privacy Officer of First Medical Health Plan, Inc., PO Box 191580, San Juan, PR 00919-1580**, by email at cumplimiento@firstmedicalpr.com, by fax to 787-300-3913, or by delivering it directly to any of the Service Offices.

You may also obtain a complaint form from the Office for Civil Rights of the U.S. Department of Health and Human Services (HHS) at <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf> and mail it directly to U.S. Department of Health and Human Services, 200 Independence Avenue, S.W. Room 509F HHH Bldg. Washington, D.C., 20201.

I. Information of the Individual Filing the Complaint					
Name:	Middle name:	Last Name:			
Postal address:			Plan Identification Number/Contract Number:		
Primary Phone:	Alternate Phone:	Email: _____			
<input type="checkbox"/> I authorize FMHP to send information to my email in a secure (Encrypted) manner					
II. How can we contact you?					
<input type="checkbox"/> Telephone	<input type="checkbox"/> Email	<input type="checkbox"/> Postal mail	<input type="checkbox"/> TTY	<input type="checkbox"/> Braille	<input type="checkbox"/> Sign Interpreters
III. Are you filing this complaint on behalf of someone else? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If your answer is yes, who is the person whose right to privacy of medical information appears to have been violated?					
First Name: _____ Last Name: _____					
IV. Description of Your Complaint					
a. Overview					
Name of the Organization/Institution/Person against whom your complaint is made:					
When did the events occur?					

b. Details of the Complaint

Provide a detailed description of your complaint, including who, what, where, when, and why. If you wish to attach a document that supports your complaint. Use additional sheets if needed and attach them to this form.

Do you have witnesses? Yes No

If you have witnesses, please provide the name and phone number of your witness(es):

Witness 1	Witness 2
Name:	Name:
Phone Number:	Phone Number:

V. Have you filed your complaint elsewhere? If so, please provide us with the following information.
(Use additional sheets if needed and attach them to this form.)

Case Filing Date:	Complaint/Case Number:
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First Medical Health Plan, Inc., may decide that your complaint does not violate the HIPAA Privacy Rule or any other applicable law or regulation, but another organization may be able to assist you, following the appropriate investigation.

VI. Signature

I certify that the information on this form is true and correct to the best of my knowledge.

Signature: _____ Date: _____

The information provided on this form is confidential and protected by the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Names or other information of individuals will be disclosed as necessary for purposes of investigating potential breaches of the privacy and security of health information, for internal systems operations, or for routine uses, including disclosing information for purposes related to compliance with the privacy of health information and as permitted by law. It is unlawful for any governed entity to intimidate, threaten, coerce, discriminate against, or retaliate against you for filing this complaint. You do not have to use this form to file a complaint. You can also write a letter or file your complaint electronically with the requested information. To file a grievance electronically, sending it to cumplimiento@firstmedicalpr.com

The Customer Service Department offers language interpreter and sign language services free of charge. This includes service alternative formats such as; Braille, enlarged print and translation into other languages, verbal or written, among others. If you need plan information in another format or language, please contact our Customer Service Department at the number on the back of your plan card.

El Departamento de Servicio al Cliente ofrece servicios de intérprete de idiomas y lenguaje de señas libre de costo. Esto incluye, servicio de formatos alternos tales como: Braille, letra agrandada y traducción a otros idiomas, verbal o escrito, entre otros. Si usted necesita información del plan en otro formato o lenguaje, por favor comuníquese con nuestro Departamento de Servicio al Cliente al número que aparece al dorso de su tarjeta del plan.

First Medical cumple con las leyes federales aplicables de derechos civiles y no discrimina en base a raza, color, origen de nacionalidad, edad, discapacidad, o sexo. **First Medical** complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex.

First Medical 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。