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.

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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