HIPAA BREACH REPORT FORM

PERSONAL AND CONFIDENTIAL

Date Breach Reported to /Received at Plan (Date of Discovery):
Date Breach Occurred (PHI accessed/transmitted/Disclosed) to unauthorized individual):

SECTION 1: Information for Person Reporting Breach

Name of person reporting Breach: **Phone No.**

Member ID# (If applicable) **Plan Provider ID# (If applicable):**

Complete Address: **Apt/Suite #:**

City: **State:** **ZIP Code:**

The person reporting the breach: ☐ **A Member** ☐ **Parent of Member** ☐ **Spouse of Member**

☐ **Designated Member Representative** ☐ **A Subcontractor/Business Associate** ☐ **A Non-Par Provider**

☐ **Other Non-Related Individual that Received the PHI/ Breached Information**

☐ **Other (explain):**

If individual reporting breach received mail for a Plan member, was the mail opened? ☐**YES** ☐ **NO**

If yes, please complete this form using the information viewed in the mailing.

If no, complete this form, as best as possible, using the information available on the envelope.

SECTION 2: Demographics of the Member Whose PHI Was Disclosed by the Breach

Member No. 1

Plan: ☐ **Simply Healthcare Plans, Inc.** ☐ **Clear Health Alliance** ☐ **Better Health, Inc.**

Line of Business: ☐ **Medicare** ☐ **Medicaid**

Name of person affected by Breach: **Member ID#:**

Complete Address: **Apt/Suite #:**

City: **State:** **ZIP Code:**

Did the breach include PHI for other Plan members? ☐ **YES** ☐ **NO**

If yes, please enter their information in Section 7 of this form.

Section 3: Member's Personal Health Information That Was Accessed or Disclosed

☐ **Name** ☐ **Address** ☐ **Phone Number** ☐ **Gender** ☐ **Date of Birth** ☐ **SSN** ☐ **Member Plan ID#**

☐ **Medicare#** ☐ **Medicaid #** ☐ **Other Insurance Information** ☐ **Diagnosis Code/Information** ☐**Plan Name**

☐ **Procedure Code/Treatment Received** ☐ **Name of Providers** ☐ **Dates of Treatment/Service**

☐ **Other:**____

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Section 4: Method of Breached PHI

Source of breached PHI: ☐ Stolen Cell Phone ☐ Stolen Desk Top Computer ☐ Stolen Laptop

☐ Stolen Tablet ☐ E-mail ☐ Phone ☐ Public Conversation ☐ Fax ☐ Copier ☐ Mail ☐ SFTP/FTP Site

Section 5: Format of PHI Disclosed

☐ Claim Form ☐ Explanation of Benefit ☐ Authorizations Letter ☐ Member ID Card

☐ Case Management /Disease Management Member Letter ☐ QM Member Letter

☐ Provider Termination Letter to Member ☐ Claim Letter ☐ New Member Mailing ☐ E-mail

☐ Disenrollment/Reinstatement/Member Letter ☐ Enrollment Verification Letter

☐ Other (Explain):

Section 6: Other Information

Who has viewed the information?

If disposed, how were it disposed of? ☐ Trashcan (Intact as received) ☐ Trashcan (Shredded into pieces)

☐ Returned to Plan via mail/Post Office ☐ Shredded

May the Plan send a representative to pick up the information? ☐ YES ☐ NO

If yes, when is best date and time for pick up?

Address for pick up? **Apt/Suite#:_____________**

If no, can you please return the information back to the Plan? ☐ YES ☐ NO

If yes, when will it be returned? **How will it be returned?** ☐ Mail ☐ In Person

If no, can the information be shredded and safely disposed of? ☐ YES ☐ NO

Section 6: Information on Person Completing This Form

Name: **Title:** **Dept:**

Phone Number: **Location:** ☐ Ponce ☐ Douglas ☐ Tampa ☐ Other

Signature: **Date:**

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SECTION 7: ADDITIONAL MEMBERS AFFECTED BY THE BREACH

Member #2:

Plan: ☐ **Simply Healthcare Plans, Inc.** ☐ **Clear Health Alliance** ☐ **Better Health, Inc.**

Line of Business: ☐ **Medicare** ☐ **Medicaid**

Name of person affected by breach: **Member ID#:**

Complete Address: **Apt/Suite #:**

City: **State:** **ZIP Code:**

Member #3

Plan: ☐ **Simply Healthcare Plans, Inc.** ☐ **Clear Health Alliance** ☐ **Better Health, Inc.**

Line of Business: ☐ **Medicare** ☐ **Medicaid**

Name of person affected by breach: **Member ID#:**

Complete Address: **Apt/Suite #:**

City: **State:** **ZIP Code:**

ADDITIONAL COMMENTS/REMARKS/SUMMARY:

Please complete this HIPAA Breach Report Form in its entirety, and submit it to the Plan via a HIPAA secure E-mail or fax using the following information: Deborah L. Polynice, LHRM E-MAIL: dpolynice@simplyhealthcare plans.com or Riskmanagement@simplyhealthcareplans.com **FAX:** 786-264-0786

This form must be submitted to the Plan within 24 hours *from the date/time or discovery of the breach.*

Revised: 10/2015