allways[sm]
HEALTH PARTNERS

MEMBER RECORDS REQUEST

Member Name: _____

Member ID Number_____

Address: _____
(must match the address on file at the time of the request)

City: _____ State_____ Zip Code: _____

Home Phone # _____ Mobile/Cell #_____

Records Request Details

Records Request Type (Please check all applicable boxes)

- ☐ Behavioral Health Claims
- ☐ Medical Claims
- ☐ Pharmacy Claims
- ☐ Other (please specify) _____

Service Dates

From _____ To _____

Requestor's Signature _____ Date _____

For your convenience, you may mail, fax or email your request as follows:

Mail: AllWays Health Partners
Customer Service Department
399 Revolution Drive – Suite 820
Somerville, MA 02145

Email: customerservice@allwayshealth.org **Fax:** 617-526-1985

Please allow 30 business days for processing.