

## Community Health Plan of Washington Privacy/Security Incident Report

Use this form to report to Community Health Plan of Washington (CHPW) a potential privacy or security incident and provide as much detail as possible. If protected health information (PHI) was sent to the incorrect recipient, ask for assurance that the PHI was not kept or used. Send your completed form to one of the following:

• Email at: <a href="mailto:compliance.incident@chpw.org">compliance.incident@chpw.org</a>

• Fax at: (206) 652-7006

Mail to:

Community Health Plan of Washington

Attn: Compliance Department

1111 3<sup>rd</sup> Ave, Ste. 400 Seattle, WA 98101

## 1. Person Completing the Report

Name:		Phone:		
Business Name (if applicable):				
Email:				
Address:				
2. Incident Details				
Notification by:	Member Call	Provider Call	Self-Report	
	Other:			
Date of Report:	Date	of Incident:		
Number of Members Affected:				
Type of Material (EOB, ID Card, Roster, etc.):				
Location:	Paper/Mail E	mail Fax		

CHPW\_CM\_586\_10\_2020\_External\_Privacy\_Security\_Incident\_Report H5826\_CP\_070\_2020\_Privacy\_Security\_Incident\_Report\_C CS\_CP\_067\_2022\_Privacy\_Security\_Inc\_Report\_C



Electron	ic Medical Record	Lost Computer/PDA
☐ Media (0	CD, USB flash drive, et	c.) Other:
3. Affected Member Details		
Member Name:		Member ID:
ProviderOne Number:		<u></u>
Member Date of Birth:	Mei	mber Line of Business:
Member Phone:	Member Er	mail:
Member Address:		
1. PHI Received By/Disclosed To		
Name of Individual or Org	anization:	
Member ID or Provider NF	PI/TIN:	
Phone:	Email:	
Intended Fax Number:	Acti	ual Fax Number:
Address:		
5. Description of Incident (describ	ne what happened. Inc	clude details, names, and dates)



