# Request for External Review of Early Elective Delivery Case

**Date of request:** ____________________ *(Deadline is Feb. 15, 2020; Nov./Dec. cases deadline is Mar. 15, 2020)*

### Contact Information:

- **Name:** _____________________________________________________________________________
- **Email address:** _____________________________________________________________________________
- **Telephone number(s):** _____________________________________________________________________________

### Case Information:

- **Delivering Provider:** _____________________________________________________________________________
- **Date of internal review:** _____________________________________________________________________________
- **Internal reviewers:** _____________________________________________________________________________

### Case Description (250 words maximum): To ensure compliance with HIPAA, please refer to the guidelines below*

_________________________________________________________________________________________________
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*In accordance with the HIPAA privacy regulation’s safe harbor method, please ensure the following identifiers of the individual, or relatives, employers or household members of the individual, are removed:

| (A) Names |
| (B) All geographic subdivisions smaller than a state, including street address, city, county, precinct, ZIP code, and their equivalent geocodes, except for the initial three digits of the ZIP code if, according to the current publicly available data from the Bureau of the Census: (1) The geographic unit formed by combining all ZIP codes with the same three initial digits contains more than 20,000 people; and (2) The initial three digits of a ZIP code for all such geographic units containing 20,000 or fewer people is changed to 000 |
| (C) All elements of dates (except year) for dates that are directly related to an individual, including birth date, admission date, discharge date, death date, and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older |
| (D) Telephone numbers |
| (E) Fax numbers |
| (F) Email addresses |
| (G) Social security numbers |
| (H) Medical record numbers |
| (I) Health plan beneficiary numbers |
| (J) Account numbers |
| (K) Certificate/license numbers |

(L) Vehicle identifiers and serial numbers, including license plate numbers

(M) Device identifiers and serial numbers

(N) Web Universal Resource Locators (URLs)

(O) Internet Protocol (IP) addresses

(P) Biometric identifiers, including finger and voice prints

(Q) Full-face photographs and any comparable images

(R) Any other unique identifying number, characteristic, or code, except as permitted by paragraph (c) of this section [Paragraph (c) is presented below in the section “Re-identification”]; and

Please fax this form to the Washington State Health Care Authority: 360-586-9551

Attention: Judy Zerzan, MD, Chief Medical Officer

Once you fax your form to HCA, please send an email to Michele Kulhanek (michelek@wsha.org) with the NUMBER OF CASES you submitted for review (DO NOT send this form or any PHI to WSHA).

07/01/2019