

Instructions to complete the Highmark Health Options Member Request for an Amendment of Protected Health Information Form

Section A: Member Information

1. Write the first and last name of the member whose information is being amended.
2. Write the member's identification number.
3. Write the member's address.
4. Write the member's date of birth.
5. Write the member's telephone number.

Section B: Health Information to be disclosed

1. Write what information you would like Highmark Health Options to amend or add.
 - a. For example: all records, only records during these dates, only records related to Dr. Smith, all records relating to my rehabilitation treatment, etc.).
2. Write what changes to your records you would like us to make.
 - a. For example: the date, the diagnosis, etc.
 - b. Please note: you will need to provide documentation for the amendment.
3. Check the reason you want Highmark Health Options to amend this information.
 - a. For example: Information was incomplete, incorrect, etc.

Section C: Signature

1. This Authorization must be signed and dated by the member whose information is to be amended.
2. In order for Highmark Health Options to approve your requested amendment, we may ask you for information before deciding whether we can honor your request. If necessary, attach this information with this form when you return it.
3. If the member is unable to sign this Authorization, a personal representative with legal authority on file with Highmark Health Options may sign and date the form. If a personal representative is signing the form on the member's behalf:
 - a. Write the personal representative's relationship to the member.
 - b. Write the personal representative's telephone number.
 - c. Write the personal representative's address.

Section D: Personal Representatives

If you are completing this form on behalf of a Highmark Health Options member please indicate in this section the legal authority that gives you this right (i.e., Personal Representative form, Healthcare Power of Attorney, legal guardianship, etc.).

If you have not already done so, you will be required to complete an Authorization to Use and Disclose Form and submit it to Highmark Health Options. If the form is not on file when we receive this form, the request will be denied. The form can be obtained and returned in the same manner as the Amendment Request Form.



Member Request to Amend Protected Health Information

Section A: Member Information (Please Print)

Member Name:	Member ID:
Address:	
Date of Birth:	Telephone:

Section B: Amendment Requested:

What information would you like Highmark Health Options to amend or add?

What changes would you like us to make?

Why do you want Highmark Health Options to amend this information? The following is the reason I want my PHI to be amended (i.e., information was incomplete, incorrect, etc.):

Section C: Signature

I understand that Highmark Health Options is under no obligation to agree to this request for amendment of my PHI and understand that my request for an amendment may be declined if the protected health information or record was not created by Highmark Health Options; the protected health information is not part of the member's "designated record set;" or the protected health information or record is accurate and complete.

I understand that this request for an amendment or addition will be made part of my permanent protected health information and will be sent as part of my designated record set in response to any authorized requests for my PHI.

I understand that in order for Highmark Health Options to approve the amendment, we may ask you for additional information before deciding whether we can honor your request.

PLEASE FILL OUT THE REVERSE SIDE OF THIS FORM

I understand that if Highmark Health Options denies this request, I may have the right to request a reconsideration of the denial decision. I must submit my request for reconsideration in writing to:

Highmark Health Options WV
Attn: Enrollee Services
614 Market St.
Parkersburg, WV 26101

I understand that any form returned to Highmark Health Options incomplete will be returned to me for completion and my amendment request will not be implemented until all the information is received complete and processed.

Signature: _____ Date: _____

If this authorization is signed by someone who is not the member listed at the top of this form, attach any documents (i.e. general power of attorney) that verify the signer's authority to act for the member.

Section D: If you are a Personal Representative filling out this form for a Highmark Health Options member, please write that relationship below and the legal reason that gives you this right (i.e. Power of Attorney, guardian, etc.). If you have not done so, you will be required to fill out an Authorization to Use and Disclose Form and send it to Highmark Health Options. You can get the form and return it in the same way as the Amendment Request Form.

If you are not the member, print your name:	Relationship to member:
Legal form on file:	Telephone number:
Address:	

