

Plan Member Request to Correct or Amend a Record

Member Name (PLEASE PRINT): _____ SSN: _____

Mailing Address: Street _____

City _____ State _____ Zip _____

Complete This Section

I request that the Plan amend the Protected Health Information (PHI) in its Designated Record Set (as defined in the Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards)), as follows:

- **Specific Statement of Amendment Request**

- **Specific Reason for Amendment Request** _____

Important Information About Your Request

I understand that if the PHI this request refers to was not created by the Plan, the Plan is not required to honor my request. For example, if the information I wish to amend is in a medical report created by my physician, I must ask the physician, not the Plan, to amend the report. I also understand that if the information is not available for my inspection, is not part of the Plan's Designated Record Set, or is already accurate and complete, I cannot amend the information.

I understand that the Plan will respond to my request within 60 days. If the Plan is unable to take action within that 60-day time period, the Plan will extend the time for such action by 30 days and will send me, within the initial 60-day time period, a written statement of the reasons for the delay and the date by which it will complete its action on the request.

If the Plan accepts the requested correction or amendment, the Plan shall make the appropriate change to the PHI or record that is the subject of the request (as described in the HIPAA Privacy Standards.)

Date _____ Signature _____

Please mail to:

Benefit Services Manager
Department of Human Resource Services
Benefit Services Division
2033 K Street, NW, Suite 220
Washington, DC 20052

For Plan Use Only: Date Request Received _____

By: _____