Health Partners Plans

Request for Amendment of Protected Health Information

Use this form to allow you or your personal representative to request an amendment to your health information that Health Partners Plans maintains.

INSTRUCTIONS FOR COMPLETING THIS AMENDMENT FORM

PART 1: Member information This section should name the Health Partners Plans (HPP) member that you are referencing. Print the member's name, birth date, address, telephone number and Member ID number.

PART 2: Information to be amended/changed. HPP does not create or keep your patient medical record (e.g. chart, x-rays, test results). Contact your provider(s) for this information. HPP keeps all claim information related to your visit to a provider or hospital, hospital stay or other medical facility. In this section describe the PHI you would like amended. HPP will not be able to change information submitted by your provider. For example, this would apply to a diagnosis, the date of service or the treatment you received.

PART 3: **Review and approval.** The *member's* signature is required. If the member is incapable of signing, a personal representative may sign on the member's behalf. Parents or guardians of minors will be confirmed using information from the state. A personal representative such as an executor or someone with a power of attorney may sign his or her name in the member's place. The legal documents proving the authority of the personal representative to act for the member **MUST** be attached or on file at HPP; otherwise the personal representative's signature will be invalid and this form will **NOT** be processed.

HPP has 30 days to respond to a request for amendment. In the event the request cannot be honored within 30 days, HPP by law is granted a one-time 30 day extension.

Complete ALL sections. If information on this form is not complete Health Partners Plans will return the form and will not approve this request until it is completed in full.

CONTACT INFORMATION

RETURN YOUR FORM(S) TO THE ADDRESS LISTED BELOW.

If you have any questions or need assistance in completing this form, call the Member Relations telephone number on the back of your identification card or write to:

Health Partners Plans
HIPAA Privacy Services
901 Market Street, Suite 500
Philadelphia, PA 19107
or
Fax: 267-515-6666

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PART 1: Please PRINT the following information below.

Member Name: **Date of Birth:**

Address: **City/ZIP:**

Telephone: ( )

Member ID #:

Part 2: Requested Amendment

Describe the Protected Health Information (PHI) you would like amended._____

_____

_____

Explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete? (You may use an additional sheet of paper as needed.) _____

_____

_____

Provide date(s) of service associated with the PHI, if applicable._____

_____

_____

State reason for requested amendment. _____

_____

_____

_____

Note: If Health Partners Plans did not create the information you are requesting to amend, you should contact the entity directly to amend the information. For example, this would apply to your diagnosis, the date of service, or treatment received. If the provider consents to amend your information and notifies Health Partners Plans, we will change the information in our records. In that case, it would still be necessary to submit this form.

PART 3: Signature

I have read and understand the above information:

Name of member or personal representative: _____

Signature: _____

Date: _____

If you are a personal representative, state your relationship to the Member:

_____

Note that, if not already provided, we will require verification of the authority of a personal representative such as a copy of a health care, general or durable power of attorney before this request will be considered complete. If this request is made by a parent/guardian, complete the following: Member/participant is a minor ___ years of age. If you are making this request on behalf of a minor child, we may require additional information such as a court order or other documentations that shows custody or other legal document showing the authority of the legal representative to act on the member's behalf before this request is considered complete.