Individual Request to Correct or Amend a Record Maintained by Health Advantage

Date _____________

Member Name ____

Address ____

Member Identification Number ____

I request Health Advantage (the health plan) to amend the protected health information of _______________________________ (name of the member) in its designated record set within the date range of _______________ through _______________

Specific Amendment Request

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Specific Reason for Amendment Request

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I understand that if the protected health information was not created by Health Advantage, the health plan is not required to honor my request. For example, if the information I wish to amend is a medical report created by my physician, I must ask the physician – not Health Advantage – 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 Health Advantage will respond in writing to my request within 60 days.

Signature: ____ Date: ______________________

Send completed form to: Privacy Office
P.O. Box 3216
Little Rock, AR 72203