Individual Request to Correct or Amend a Record Maintained

Full name			**Date of birth**
Member ID number	**Line of business** ☐ Arkansas Blue Cross and Blue Shield ☐ Federal Employees Plan		
Current address	**City**	**State**	**ZIP**

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

Specific reason for amendment aequest

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 signed (mm/dd/yyyy)

Please return this signed form to:
Privacy Office
P.O. Box 3216
Little Rock, AR 72203