

Amendment Request

Purpose: This form is used to make a request to amend or revise of your protected health information maintained by your insurer or its Business Associates. Please check the insurer whose name appears on your health benefits identification card.

____ CareFirst BlueCross BlueShield* ____ CareFirst BlueChoice ____ Federal Employee Program

Please type or print neatly; we will not process incomplete or illegible forms.

Section A: INDIVIDUAL REQUESTING AMENDMENT

Last Name: _____ **First Name:** _____ **MI:** _____

If not the Policy Holder, Name of Policy Holder:

Last Name: _____ **First Name:** _____ **MI:** _____

Street Address: _____ **Apt #:** _____

City: _____ **State:** _____ **Zip:** _____

Phone: (home) _____ **(work)** _____

Member ID#: _____ **Date of Birth:** ____/____/____

Note: This is the number on your health benefits identification card.

Section B: TO THE INDIVIDUAL — Please read the following and complete the information requested.

You have the right to request that CareFirst amend/revise your protected health information in our records. CareFirst may decline your request if: (1) we did not create the information, (2) we believe the information is complete and accurate, or (3) the information is (a) psychotherapy notes, (b) compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding, or (c) not subject to disclosure to you under the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C. § 263a).

Please specify the records you wish to amend/revise: _____

Please state the amendments/changes: _____

Please state the reasons for the amendments/changes: _____

Please send the name and address of each person or entity to whom you want us to send notification of the amendment/changes should we agree to make the changes you request. You must also provide CareFirst with a signed authorization for us to notify these persons or entities. We will direct you to or provide you with the appropriate authorization form upon request. Please contact member services at the number listed on your benefits card or the CareFirst Privacy Office at 1-800-853-9236. CareFirst will also notify its Business Associates.

Name of
Person/Entity: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____

Print Name:

If this request is made by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

- A copy of my personal representative form or legal document is on file.
- Attached is a copy of my personal representative or legal document.

Please mail or fax the completed form to:

CareFirst BlueCross BlueShield
Attention: Privacy Office
10455 Mill Run Circle
Owings Mills, MD 21117
Fax: 410-505-6692

Please keep a copy of this request for your records.