BLUE Benefit
ADMINISTRATORS OF MASSACHUSETTS
An independent licensee of the Blue Cross and Blue Shield Association.

PHI AMENDMENT REQUEST

Purpose: This form is used for an individual's request to amend protected health information in designated record sets that we maintain or that our business associates maintain for us.

SECTION A: Individual requesting records amendment.

Name:

Address:

Telephone: E-mail:

Identification Number: Social Security Number:

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

You have the right to request us to amend your protected health information in our designated record sets. We may decline your request if the information is not part of our designated record sets, we did not create the information, we believe the information is complete and accurate, and for certain other reasons. To exercise your right to request amendment, please complete Section B.

SECTION B: Protected health information to be amended.

Please specify the records you wish to amend and the amendment you wish to make:

Please state the reason for the amendment:

Please list the name and address of each person who you want us to notify of the amendment, should we agree to make the amendment you request. You must provide us with a signed authorization for us to notify these persons. We can supply you with the appropriate authorization form.

INDIVIDUAL'S SIGNATURE.

Date:

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

Personal Representative's Name:

Relationship to Individual:

YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT

Return form to:

BLUE Benefit Administrators of Massachusetts
Attention: HIPAA/Privacy Officer
PO Box 55917, Boston, MA 02205-5917
FAX# 877-596-2583