Amendment Request

Purpose: This form is used to make a request to amend your protected health information created and maintained by your insurer or its Business Associates.

CONTACT CUSTOMER SERVICE TO CHANGE YOUR NAME, ADDRESS OR DATE OF BIRTH – DO NOT USE THIS FORM

Note: If the information that needs to be changed was created by a provider please contact the provider directly to change the information.

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

Section A: AMENDMENT FOR THE FOLLOWING INDIVIDUAL

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

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

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

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

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

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

You have the right to request that NCAS amend/revise your protected health information in our records. NCAS 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 advise the records you wish to amend/revise and state the specific changes to be made:

_____

_____

_____

_____

Please state the reasons for the amendments/changes: _____

_____

_____

Section C: Name and Address of Persons to Notify

Please list the name and address of anyone you want us to send notification of the amendment/revisions should we agree to make the changes you request. Please include a signed authorization for CareFirst to notify these persons or entities. NCAS will also notify its Business Associates of any changes granted.

Name of Person/Entity: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Name of Person/Entity: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Name of Person/Entity: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Section D: Signature and Date:

Signature: _____ Date: _____

Print Name: _____

Must be the original signature of any person 18 years of age or older whose records have been requested.

If this request is made by a personal representative on behalf of the individual please attach a complete copy of the personal representative form or legal document indicating your legal authority to sign this form.

Please mail or fax the completed form to:

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

Please keep a copy of this request for your records.