PROVIDENCE Health Plan

Member Request to Amend a Designated Record Set

If you have questions, please contact Customer Service at 503-574-7500 (toll-free 1-800-878-4445; TTY 503-574-8702 / 1-888-244-6642) or via the Web at www.providence.org/healthplans

MEMBER INFORMATION			
MEMBER LAST NAME	MEMBER FIRST NAME	MEMBER MIDDLE NAME	
DATE OF BIRTH __ __/ __ __/ __ __ __ __	MEMBER ID#	GROUP ID#	
STREET ADDRESS			
CITY	STATE	ZIP CODE	PHONE NUMBER

After review of my record, I do not feel that original documentation made by _____ accurately reflects medical services provided, inquires made, claims payment or denied on the following date (____ /____/ _____). I am requesting a correction or addendum to _____ (identify specific document in question) contained in my medical record.

I request the following correction/amendment be made to my claims and enrollment record.

_____

_____

Please send a copy of the corrected/amended documents to the company or individual listed below:

Company:_____ Name: _____

Address: _____City:_____ State: _____Zip:_____

I understand that Providence Health Plans (PHP) may or may not supplement my record with an addendum based on this request. PHP is not allowed to alter the original documentation in my record. My request for amendment and any action taken on this request, will become a permanent part of my record, and will be included with any future authorized disclosures.

PHP will provide a response to this request within sixty days. I can provide a statement of disagreement if PHP denies my request. If I am not satisfied with the action taken with respect to this amendment process, I can write PHP at PO Box 4327, Portland, OR 97208-4327 and report my concerns.

Please sign and date:

_____ _____
Member or Representative's signature Date

_____ _____
Printed Name of Representative (if applicable) Relationship to Member

FOR OFFICE USE ONLY

Date received:_____ Sent to:_____ Title:_____ Date: _____

☐ Amendment Accepted

☐ Denied: Records are Accurate and Complete

☐ Denied: Other (state reason) _____

By:_____ Title:_____ Date: _____

Member notified:

By:_____ Title:_____ Date: _____