Return To: CountyCare Health Plan
ATTN: Compliance
300 S Riverside Plaza, 4th Floor
Chicago, Illinois 60606
Fax: (312) 548-9940

REQUEST TO AMEND PROTECTED HEALTH INFORMATION (PHI)

Use this form to request an amendment to your health information maintained by CountyCare, or entities on behalf of CountyCare. If CountyCare is not the originator of the information you are requesting to amend, you will need to contact the originator directly to amend the information. For example, we likely cannot amend information related to diagnosis, date of service, or treatment received. You will need to contact your provider to amend this information. If your provider consents to amend your information and notifies CountyCare, we will change the information in our records. If you need assistance completing the form, please contact the Customer Service number at **312-864-8200.**

I. MEMBER INFORMATION: (Name and information of individual for whom amendment is being requested.)

Name: _____

Address: _____

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

II. REQUEST: (Information regarding the information that you would like amended.)

Describe the PHI to be amended: _____

Requested change: _____

Date(s) of service associated with the PHI (if applicable): _____

Reason for requested amendment: _____

If CountyCare Health Plan approves this request to amend, the amended information will be included in all future disclosures and correspondence. CountyCare Health Plan will provide the amendment to individuals/ organizations you identify below.

Please list the name(s) and address(s) of individuals or organizations to notify should CountyCare agree to make the amendment:

III. SIGNATURE

I request that CountyCare amend my PHI as specified in section II above. I have read and understand the above information.

The member must sign this form to authorize CountyCare Health Plan to amend his/her PHI. If the member cannot sign, only the member's legal representative may sign. If you are the member's legal representative, describe this below and send CountyCare Health Plan copies of those forms (such as power of attorney or order of guardianship). Members 18 years or older must sign the form on their own behalf.

Signature of Member: _____ Date: _____

Signature of Representative (if applicable): _____

Relationship to the Member: _____

FOR COUNTYCARE USE ONLY

Date amendment request received: _____ *Extension requested:* ☐ *Yes* ☐ *No*

Reason for extension (if yes): _____

Member notified in writing of decision on this date: _____ *Decision Appealed:* ☐ *Yes* ☐ *No*

Name of staff member processing request: _____