Live and Work Well

Request to Amend Protected Health Information

In accordance with the Health Insurance Portability and Accountability Act (HIPAA), you have the right to request that protected health information (PHI) maintained about you in a Designated Record Set (DRS) be changed or amended. PHI includes enrollment information, claim requests for payment, claim payment, case or medical management records, appeals and/or complaint files, and other records that are used in whole or in part to make decisions about your benefits.

Use this form to request that PHI contained in your DRS that is incomplete or inaccurate be changed or corrected. For example, there is information incorrectly stated in clinical notations or there is an incorrect diagnosis in your record.

Your request may denied if the PHI that is the subject of the request:

a) Was not created through or is not part of your behavioral or Employee Assistance Program (EAP) DRS;
b) Is not available for inspection (including, but not limited to, exempt items like psychotherapy notes and situations in which the PHI at issue is no longer maintained in the DRS); or
c) Is accurate and complete.

When completing this form, please:

- Complete all sections entirely;
- Print information clearly;
- Provide us with your most current information.

You can only request to correct or amend your own PHI, unless you are authorized to amend information about someone else. We will respond to requests from a personal representative authorized by a member to receive his or her PHI (e.g., parent, court appointed representative, family member). However, we may ask for more information from you or your authorized representative to verify the right to act on your behalf.

Please note: If you are a guardian or court appointed representative for the individual, you must attach copies of your authorization to represent the individual in order to obtain access to his/her PHI.

Please note that entities will only amend PHI regarding benefits and programs they administer. To correct or amend PHI beyond your behavioral health and EAP healthcare information covered by this form, you must contact each entity that administers your benefit directly. To update your address, phone number or billing information, please call customer service at the telephone number located on your health ID card or contact your employer group directly.

We will respond to your request for an amendment of PHI or provide a status update within 60 days from the date we receive your request.

If you have questions about this form, please call the number located on your health ID card to speak with a customer service advocate.

This Request to Amend Protected Health Information form is for use by UnitedHealthcare and Optum members and their personal representatives. UnitedHealthcare behavioral health benefits are managed by Optum.

Request to Amend Protected Health Information (PHI)

This form is used to request an amendment of PHI contained in a DRS relating to behavioral or EAP services. To amend PHI concerning benefits or programs that are not for behavioral or EAP services, you must contact the entity that administers those benefits directly. Once the decision to grant or deny your request has been made, a letter explaining our decision will be mailed to you or your authorized personal representative. Please print. Be sure to complete both pages of this form.

Section 1: Amendment of PHI Requested For:

Name_____Address_____

City_____ State____ Zip_____Phone (_____) -_____

Date of Birth _____ Male ___ Female ____

Relationship to Subscriber: Self____ Spouse ____Child____If other, describe type of relationship _____

Section 2: Amendment Requested:

Please indicate the PHI that you believe is inaccurate and/or incomplete and describe the error. If the information relates to a claim, date of service, authorization for treatment, etc., please indicate any claim numbers, dates, or other information that will assist us in processing your request. Please attach a copy of the information you would like amended.

_____
_____
_____
_____

If you know that someone else has this information and should be notified if we make an amendment, please list them below:

Name	Address	Relationship (e.g., Provider, plan sponsor, etc.)

Section 3: Signature of Member or His/Her Personal Representative:

Authorized Signature of individual or personal representative of individual, for whom the amendment is being requested:

I authorize the amendment of the indicated PHI to be sent to me; to others as directed in a signed authorization; or to others legally authorized to act on my behalf, at the address stated in Section 1 of this form.

Signature of Individual: X _____Date_____

Signature of Personal Representative, if applicable: X _____ Date_____

Representative's Name_____Address_____

City_____ State ____Zip _____ Phone (_____)_____

Relationship to individual and authority to act for individual:_____
_____

Important: A personal representative, including a parent, legal guardian, or executor of an estate, may be required to attach a copy of legal documentation to this request form.

Section 4: Subscriber Identification

Identification Number_____ Group Number_____Employer_____

Subscriber Name _____

Address _____

City_____ State_____ Zip_____ Phone (_____)_____

Please return the completed form to:
Fax: 888-371-7011
Or

Mail to:

Privacy Administrator
MN101-E013
11000 Optum Circle
Eden Prairie MN 553344