Request to Amend Protected Health Information

Use this form to request an amendment of your protected health information (PHI) in records that we, or our business associates, maintain in designated record sets.

Please complete the following:

Name:		Phone:
Address:		City:
State:	ZIP code:	Member ID number:

Please read and complete the following: You have the right to request that we amend your PHI in the designated record set that we or our business associates maintain. We may decline your request if we did not create the records; the records are not part of our designated record set; the law does not give you the right to access the records; or the records are complete and accurate.

To exercise your right, please specify which records you want to amend and the amendments you want made to them:

Please specify the reason(s) for the requested amendments:

Please sign and date:

Signature:	Date:

Personal representative: If you are not the member, please sign and date below. Check the box that describes your relationship to the member. **If you are not the parent or legal guardian, please attach proof of your relationship to the member (e.g., power of attorney, personal representative documentation, etc.).**

Print name of personal representative:
Signature of personal representative and date:

☐ Parent or legal guardian ☐ Power of attorney ☐ Executor ☐ Other:_____

Please return this form to: AmeriHealth Caritas VIP Care
Medicare Compliance
3875 West Chester Pike
Newtown Square, PA 19073