BlueCross BlueShield of Illinois

Request to Amend Protected Health Information (PHI)

Use this form to request an amendment to your PHI in the Designated Record Set(s) that Blue Cross and Blue Shield of Illinois or its Business Associates maintain. If you need assistance completing the form, please contact the Customer Service number listed on your Member Identification Card. You must complete all the fields on this form.

WHEN COMPLETED AND SIGNED PLEASE MAIL TO: **Blue Cross and Blue Shield of Illinois**
P.O. Box 660044
Dallas, TX 75266-0044
OCA_SSD@bcbstx.com

Section A: The individual for whom amendment is being requested. Please complete the following:

Name ______ **Group #** ______ **Identification\Subscriber #** ______

Social Security Number ______ **Date of Birth** ______

Address ______ **City** ______ **State** ______ **ZIP** ______

Area Code & Telephone Number ______ **E-mail address (if available)** ______

Section B: Please place an "X" in the box next to the records you are requesting be amended, include specific dates:

Enrollment Records	From:	To:	Claim Records	From:	To:
☐ Application/Underwriting/Attending Physician Statement Record			☐ Medical		
			☐ Dental		
☐ Premium Payment/Billing History (if applicable)			☐ Prescription Drugs		
			☐ Vision		
			☐ Mental Health		

Please state the reason(s) you feel these records should be amended:

______

Section C: Please list the name(s) and address(es) of individuals to notify should we agree to make the amendment.

Name ______ **Name** ______

Address ______ **Address** ______

City, State, ZIP ______ **City, State, ZIP** ______

Section D: Signature –This document must be signed by the individual, parent of minor child or the individual's Personal Representative.

I request that Blue Cross and Blue Shield of Illinois amend my PHI as specified in Section B above. I understand that I can only sign on behalf of a minor child under the age of 18, unless there is proof of legal guardianship.

Signature ______ **Date: month/day/year** ______

Section E: If Section D is signed by a Personal Representative, please complete the information below:

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator, please attach a copy of the Legal documents. You do **NOT** have to attach copies of these documents if they are already on file with Blue Cross and Blue Shield of Illinois.

Personal Representative's Name ______ **Relationship to Individual** ______

Personal Representative's Address ______ **City** ______ **State** ______ **ZIP** ______

Personal Representative's Area Code & Telephone Number ______ **Personal Representative's E-mail address (if available)** ______

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