BlueCross BlueShield of Illinois

Denied Amendment Response

Use this form to respond to our denial of your Amendment Request or to request that your original amendment request and our denial be attached to future disclosures of the Protected Health Information (PHI) that you wanted amended. 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. We will need a copy of our original denial letter in order to respond to this request.

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 was denied. 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 select the appropriate option. You may select only one:

☐ **Option 1:** I request that you attach the following Statement of Disagreement to my Designated Record Set. (Please limit your response to the space provided below.)

☐ **Option 2**: I do not choose to submit a Statement of Disagreement. Instead, I request that you include my original Request for Amendment and subsequent denial with any future disclosures of the PHI that I requested be amended.

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

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 D: If Section C 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)**

Any changes to the format, content or branding of this form are strictly prohibited without review and approval of the HCSC Privacy Office.