Amendment of PHI Request Form

Western Health Advantage

Mail to: Western Health Advantage Mail Service, Attn: Member Services
PO Box 4457, Portland, OR 97208-4457
Fax to: 916.678.5440
Questions? 916.563.2250 | 888.563.2250 toll-free | 711 TTY

Member Information

First Name _____ Last Name _____ MI _____

WHA Member ID#_____ Date of Birth _____

Address_____ Apt./Unit#_____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

This form will allow a member to request for an amendment of Protected Health Information (PHI) in the designated record set maintained by Western Health Advantage (WHA). Requests for amendment of medical records should be submitted directly to the healthcare provider.

Amendment Requested

Describe the PHI or document you would like amended

_____

Specify change/amendment you want to make on the document or information

_____

Date(s) of service associated with the PHI or document, if applicable _____

Reason for requested amendment (or reason why the entry is incorrect or incomplete)

_____

If granted, would you like this amendment sent to anyone whom we may have disclosed information in the past? If yes, please specify the name(s) and address(es) below:

Name of Person or Entity _____

Address _____

Name of Person or Entity _____

Address _____

Western Health Advantage is an HMO plan with a Medicare contract. Enrollment in the health plan depends on contract renewal.

I understand and agree to the following:

- If my request is granted, WHA will notify other persons or Business Associates it knows who have my PHI that needs to be amended and have relied or may rely on it.
- My request will be processed within sixty (60) days, or I will be informed in writing of the need for an extension of not more than 30 additional days to process the request.
- This request for amendment of information may be denied. The reasons for denial may include (a) the PHI was not created by WHA and the originator of PHI is still available to act on my request, (b) the information requested is not part of a designated record set, (c) the request covers psychotherapy notes or information WHA has compiled in anticipation of or for use in civil, criminal or administrative actions or proceedings, or (d) the PHI or record is accurate and complete.
- If denied, I have the right to submit a written statement of disagreement, detailing the basis for it, contained on one typed page of at least 10-point font; OR if I do not submit a written statement of disagreement, I understand that I may ask that my request for amendment and the denial be disclosed with any future disclosures of information that is the subject of the amendment. My statement of disagreement or request for this type of disclosure should be in writing to the Privacy Officer, Western Health Advantage, 2349 Gateway Oaks Dr., Suite 100, Sacramento, CA 95833.

WHA Member Signature _____ Date _____

Print Name _____

Personal Representative Signature _____ Date _____

Print Name _____

Please check the box that describes your relationship to the member/enrollee:

❏ Parent of Minor ❏ Legal Guardian ❏ Power of Attorney ❏ Executor

❏ Other _____

Documentary proof of your relationship/authorization must be attached to this request, otherwise it cannot be processed or may be denied. If you are requesting an amendment on behalf of a minor, federal and state laws may prohibit WHA from acting on your request about information relating to sensitive services without written authorization from the minor 12 years of age or older.

Keep a copy of this for your records.

WHA Internal Use Only

Date Request Received _____ Date Request Fulfilled/Denied _____

❏ Identification Verified (documents checked)

If Denied, reason for denial _____

Signature of Manager or Supervisor _____

Printed Name _____