# Request to Amend Protected Health Information

**This form is used to request an amendment to Protected Health Information contained in a Designated Record Set that has been maintained by UMR. To amend PHI concerning your other benefits not managed by UMR, 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 sides of this form.**

## Section 1: Amendment of Protected Health Information 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 Protected Health Information 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 Protected Health Information 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 MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS**

**Please return the completed form to:**


**UMR**
**Customer Service Privacy Unit**
**PO Box 8006**
**Wausau WI 54402**

**Fax: 715-841-6195**


**Revised: 8.5.11**