

Amendment Request

Purpose: Use this form to ask us to correct or change your health records.

Member Information

Name _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Phone # _____ Email _____ BCBSAZ ID# _____

Please Read this Notice:

You can ask us to correct the records we have for you. We may not agree if:

- The information isn't part of your record set
- We did not create the record
- We believe the information is correct
- It is for psychotherapy notes
- The information is for a planned lawsuit
- Is not something we can disclose to you

Tell us what records to correct and the changes you want: _____

Tell us why these changes are needed. Add other papers that support your request: _____

Please tell us who you want us to notify of the change to your records. Include their name and address. We will contact them if we agree to make the changes. You must give us a signed authorization to contact them. We will consider this signed form as your okay to notify them.

Signature

Signature _____ Date _____

If you are the personal representative of the member, complete this:

Representative's Name: _____ Relationship to Member: _____

(Note: If you are filling out this form for someone else, please tell us why you can do this. Also, attach a copy of any legal papers that apply.)

YOU CAN GET A COPY OF THIS REQUEST

Please send the completed form to us. You can mail it to: BCBSAZ Privacy Office, Mail Stop C300, P.O. Box 13466, Phoenix AZ 85002-3466. Email it to: privacy@azblue.com or Fax it to (602) 544-5661.

Notice of Non-Discrimination

Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to people with disabilities to communicate effectively with us. BCBSAZ also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call 602-864-4884 for Spanish and 877-475-4799 for all other languages and other aids and services.

If you believe that BCBSAZ has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: BCBSAZ's Civil Rights Coordinator, Attn: Civil Rights Coordinator, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466, 602-864-2288, TTY/TDD 602-864-4823, crc@azblue.com. You can file a grievance in person or by mail or email. If you need help filing a grievance BCBSAZ's Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

