# *Request to Amend Private Health Information*

**THIS FORM WILL ALLOW ME TO REQUEST AN AMENDMENT OF MY PRIVATE HEALTH INFORMATION (PHI) THAT SIMPLICITY HEALTH PLANS* MAINTAINS.**

## VERIFICATION INFORMATION *(Please Fill in Form or Print Clearly)*

**Identification of Member/Participant requesting PHI:**

*(The following information is needed for verification. Please complete all applicable items)*

Name of Member/Participant: _____ Date of Birth: _____/_____/_____

Daytime Phone #: (_____) _____-_____ Evening Phone (_____) _____-_____

*(Phone Number is required and necessary if we need to contact you to process your request)*

Social Security #: _____-_____-_____

Member/Participant ID card # *(if applicable)*: _____

Group # on ID card: _____

Subscriber Name *(if different from Member/Participant)*: _____

Subscriber's Relationship to Member/Participant: _____

Subscriber's Employer Name: _____

Subscriber's Social Security # *(if different from Member/Participant)*: _____-_____-_____

**If you have additional coverage with another employer plan managed by SIMPLICITY HEALTH PLANS, other than described above, please complete the following information:**

Other Employer Name: _____

City: _____ State: _____ Zip: _____

Member/Participant ID card #: _____

Group or Account # on ID card: _____

## INFORMATION REQUESTED TO BE AMENDED

If Simplicity Health Plans was not the originator of the information you are requesting to amend, you should contact the originator directly to amend the information; for example, your diagnosis, the date of service, or the treatment received. If the provider consents to amend your information and notifies Simplicity Health Plans, we will change the information in our records. In that case, it would not be necessary to submit this form.

If Simplicity Health Plans approves your request to amend, the amended information will be used and included in all future disclosures, including correspondence. We will provide the amendment to persons who previously received the information if we believe they have relied or will rely on that information to your detriment. Also, we will provide the amendment to individuals/organizations you identify below.

**Names & addresses of individuals/organizations to whom you request amended information be sent, if request is approved:**

*Name:* _____
*Address:*_____
*City:* _____ *State:* _____ *Zip:* _____

*Name:* _____
*Address:*_____
*City:* _____ *State:* _____ *Zip:* _____

*Name:* _____
*Address:*_____
*City:* _____ *State:* _____ *Zip:* _____

***If you need more space, use the back of this sheet. Please print clearly.***

**Describe the Private Health Information (PHI) you would like amended:**

Service:_____**Date:** _____/_____/_____ (mm/dd/yyyy)
Specify change/amendment requested: _____
Reason for requested amendment:_____

Service:_____ **Date:** _____/_____/_____ (mm/dd/yyyy)
Specify change/amendment requested: _____
Reason for requested amendment:_____

Service:_____ **Date:** _____/_____/_____ (mm/dd/yyyy)
Specify change/amendment requested: _____
Reason for requested amendment:_____

***If you need more space, use the back of this sheet. Please print clearly.***

## PLEASE NOTE

- This amendment of your private (protected) information **only includes information that Simplicity Health Plans, its affiliates and business associates maintains**. It does not include information that may be maintained by the subscriber's employer/group health plan, their business associates, or other insurers of the group health plan that may administer your health care benefits. You should contact your employer or those entities to obtain additional information.

- If the information on this form is not complete, Simplicity Health Plans will return the form to you, and this request will not be considered until Simplicity Health Plans has received complete information.

## SIGNATURE

**I have read and understand the above information.**

_____Date:_____/_____/_____

***Signature of Member/Participant/Parent/Guardian***

**If request is made by a Parent/Guardian for a minor child, complete the following:**

I hereby certify that the Member/Participant _____ is a minor _____ years
***(Insert Name of Minor, Member/Participant here)***
of age and that I am the parent and/or legal guardian of this minor. *(If you are making this request on behalf of a minor child, we may require additional information before this request is considered complete).*

## Please Return This Completed Form To:

**Simplicity Health Plans**
**HIPPA Amend**
**20600 Chagrin Blvd. Suite 450**
**Cleveland, Ohio 44122**