8/1/18

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REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

About You

Subscriber Name: _____

Address: _____

Subscriber ID Number: _____ **Telephone Number:** _____

Member Name: _____ **Date of Birth:** _____

Please place a check mark in front of each plan you want this Amendment request to be applied:

- ☐ GEHA Health Plan
- ☐ GEHA Connection Dental Federal Plan
- ☐ Connection Dental *Plus* Plan
- ☐ CONNECTION Vision Plan

Information You Would Like Amended

Description of Amendment Requested _____

_____

_____

Dates of Service from: _____ **to** _____

ATTACH COPY OF ALL INFORMATION (i.e. claim, records, etc.) TO BE CONSIDERED FOR AMENDMENT.

Individual(s) I Would Like Notified if Amendment is Accepted:

Name(s): _____

Address(s): _____

Signature and Acknowledgement

- I understand that my request will be processed within 60 days. GEHA may take up to 30 additional days to fulfill the request, but will inform me within 60 days of receipt of the request of the need for an extension.
- I understand that this request may be denied in whole or in part. If so, I have the right to submit a statement of disagreement and understand that GEHA will communicate these rights in the case it denies my request.

Date: _____

Patient or Legal Representative Signature: _____

Relationship to patient: _____
(i.e. parent, legal guardian, medical power of attorney, etc.)

NOTE: If the signature is not that of the patient or the parent when the child is a minor, appropriate legal documentation is required to accept the signature.

PLEASE RETAIN A COPY FOR YOUR RECORDS AND RETURN THE ORIGINAL SIGNED FORM TO:

ATTN: Amendment Request
GEHA
P.O. Box 21542
Eagan MN 55121
FAX: 816.257.3283