



Request to amend protected health information

This form is used to request an amendment to protected health information (PHI) in a Designated Record Set (DRS) that has been maintained by EmblemHealth and UnitedHealthcare. To amend PHI concerning your other benefits not managed by EmblemHealth and UnitedHealthcare, 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 and complete both sides of this form.

Amendment of PHI requested for

Name _____ Street address _____

City _____ State _____ ZIP _____ Phone number _____ - _____ - _____

Date of birth / / Gender Male Female Non-binary Other (specify) _____
MM DD YYYY

Relationship to subscriber Self Child If other, describe relationship _____

Amendment requested

Please indicate the PHI that you believe is inaccurate 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.)

Signature of member or their personal representative

Authorized signature of the individual, or the personal representative of the individual, about whom the PHI is being requested:

I authorize the amendment of the indicated PHI to be sent to me; to others as directed in the prior section; or to others legally authorized to act on my behalf at the address stated in Section 1 of this form.

Signature of individual _____ Date / /
MM DD YYYY

Signature of parent or personal representative (if applicable) _____ Date / /
MM DD YYYY

Representative's name _____ Street address _____

City _____ State _____ ZIP _____ Phone number _____ - _____ - _____

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.

Subscriber identification

NYCE PPO member ID _____ Group number _____

Subscriber name _____ Street address _____

City _____ State _____ ZIP _____ Phone number _____ - _____ - _____

Please maintain a copy of this document for your records.

Please return the completed form to: **NYCE PPO Plan**
P.O. Box 21534
Eagan, MN 55121

Fax: 888-742-4179