

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 United Behavioral Health, or its affiliate U.S. Behavioral Health Plan of California (USBHPC). To amend PHI concerning your medical, dental or any other covered entity benefit not managed by UBH or its affiliates, 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. If you have questions please call 1-866-604-3273 and dial "0" for a Customer Service Representative who can answer your questions about legal documentation.

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Section 4: United Behavioral Health Subscriber Identification

Identification Number _____ Group Number _____ Employer _____

Subscriber Name _____

Address _____

City _____ State _____ Zip _____ Phone (_____) _____

Please return the completed form to:
United Behavioral Health
Compliance Department – Privacy Lead
P.O. Box 99378
Emeryville, CA 94662-9378