Request to Amend Protected Health Information (PHI)

By law an individual has the right to amend his or her PHI in the Designated Record Set(s) that FirstCare Health Plans or its Business Associates maintain, as well as to request an amendment to your Protected Health Information (PHI). **If you need assistance completing the form, please contact the Customer Service number listed on the back of your Member Identification Card.**

WHEN COMPLETED AND SIGNED PLEASE MAIL TO: **FirstCare Health Plans**
12940 N HWY 183
Austin, TX 78750

Section A: The individual for whom amendment is being requested. Please complete the following:

Name ____________ **Group #** ____________ **Identification\Subscriber #** ____________

Social Security Number ____________ **Date of Birth** ____________

Address ____________ **City** ____________ **State** ______ **ZIP** ______

Area Code & Telephone Number ____________ **E-mail address (if available)** ____________

Section B: Please place an "X" in the box next to the records you are requesting be amended, include specific dates:

Enrollment Records	From:	To:	Claim Records	From:	To:
☐ Application/Underwriting/Attending Physician Statement Record			☐ Medical		
			Dental		
Premium Payment/Billing History (if applicable)			Prescription Drugs		
			Vision		
			Mental Health		

Please state the reason(s) you feel these records should be amended:

____

Section C: Please list the name(s) and address(es) of individuals to notify should we agree to make the amendment.

Name ____________ **Name** ____________

Address ____________ **Address** ____________

City, State, ZIP ____________ **City, State, ZIP** ____________

Section D: Signature – This document must be signed by the individual, parent of minor child or the individual's Personal Representative.

I request that FirstCare Health Plans amend my PHI as specified in Section B above. I understand that I can only sign on behalf of a minor child under the age of 18, unless there is proof of legal guardianship.

Signature ____________ **Date: month/day/year** ____________

Section E: If Section D is signed by a Personal Representative, please complete the information below:

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator, please attach a copy of the Legal documents. You do **NOT** have to attach copies of these documents if they are already on file with FirstCare Health Plans.

Personal Representative's Name ____________ **Relationship to Individual** ____________

Personal Representative's Address ____________ **City** ____________ **State** ______ **ZIP** ______

Personal Representative's Area Code & Telephone Number ____________ **Personal Representative's E-mail address (if available)** ____________