



MASSACHUSETTS Request to Amend Protected Health Information

Use this form to request an amendment to your Protected Health Information (PHI) that Blue Cross Blue Shield of Massachusetts (Blue Cross) maintains in a designated record set.

Please retain a copy of this form for your records and mail or fax completed form to:
Blue Cross Blue Shield of Massachusetts, Inc.
101 Huntington Avenue – Suite 1300
Boston, MA 02199-7611
Attention: Law Department – Mailstop 01/18
Privacy Program Manager
Fax: (617) 246-3550

A. MEMBER INFORMATION

Member's name: _____ Member's ID#: _____

Date of Birth: _____ Date of request: _____

Address: _____

Phone number: _____

B. INFORMATION REQUESTED TO BE AMENDED

Describe the PHI you would like amended *(attach additional pages if necessary):*

Specify change/amendment requested *(attach additional pages if necessary):* _____

Date(s) of Service associated with the PHI, if applicable: _____

Reason for requested amendment *(attach additional pages if necessary):* _____

C. IMPORTANT NOTES

- If Blue Cross was not the originator of the information you are requesting to amend, you should contact the originator directly to amend the information. For example, this would apply to your diagnosis and the treatment received. If the provider agrees to amend your information and notifies Blue Cross, we will amend the information in our records without need for this form. If Blue Cross was not the originator of the information, then your request may not be granted unless you provide a reasonable basis to believe that the originator of PHI is no longer available to act on the requested amendment.
- If Blue Cross approves your request to amend, the amended information will be used and included in all future disclosures. We will provide the amendment to persons who previously received the information if we believe they have relied on or will rely on the information to your detriment. We will also provide the information to individuals/organizations that you identify below who have received the un-amended PHI.
- Blue Cross may deny your request if the PHI or record that is the subject of this request: (i) is not part of your designated record set; (ii) would not be available for inspection under applicable law dealing with access to PHI; or (iii) is accurate and complete.
- Blue Cross will respond to your request within sixty (60) days of receipt of your request, or you will be informed in writing of the need for an extension of not more than thirty (30) days to process the request. If the information on this form is not complete, Blue Cross will return the form to you, and this request will not be considered until Blue Cross has received complete information.
- If your request is denied, you may: (i) submit a statement disagreeing with the denial; (ii) request that your original amendment/correction request and denial be attached to future disclosures of your protected health information; and (iii) file a complaint with the Blue Cross Privacy Officer at the address above, or with the Secretary of the Department of Health and Human Services pursuant to procedures established in 45 C.F.R. § 160.306.

D. NAMES/ADDRESSES OF INDIVIDUALS/ORGANIZATIONS TO WHOM YOU REQUEST THE AMENDED INFORMATION BE SENT, IF YOUR REQUEST IS APPROVED:

E. SIGNATURE

The member named above should be the person signing this request form. If the member is a minor, a parent or legal guardian must sign. If this form is completed by a Legal Representative, other than parent (i.e., a person who has legal authority to act on the member's behalf), please ensure you have completed and submitted the Blue Cross Documentation of Legal Representative Status Form prior to submitting this form to Blue Cross.

Print name: _____

Signature of member: _____

Or legal representative: _____ Date: _____

Relationship (if legal representative): _____

Questions regarding this form should be directed the Privacy Program Manager at (617) 246-3500

Blue Cross Blue Shield of Massachusetts complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, sexual orientation or gender identity.

ATTENTION: If you don't speak English, language assistance services, free of charge, are available to you. Call Member Service at the number on your ID card (TTY: 711).

Spanish/Español: ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia con el idioma. Llame al número de Servicio al Cliente que figura en su tarjeta de identificación (TTY: 711).

Portuguese/Português: ATENÇÃO: Se fala português, são-lhe disponibilizados gratuitamente serviços de assistência de idiomas. Telefone para os Serviços aos Membros, através do número no seu cartão ID (TTY: 711).