



## Request to Amend Protected Health Information (PHI)

Use this form to request an amendment to your PHI in the Designated Record Set(s) that Blue Cross and Blue Shield of Montana or its Business Associates maintain. If you need assistance completing the form, please contact the Customer Service number listed on your Member Identification Card. You must complete all the fields on this form.

**WHEN COMPLETED AND SIGNED PLEASE MAIL TO: Blue Cross and Blue Shield of Montana  
P.O. Box 660044  
Dallas, TX 75266-0044  
[OCA\\_SSD@bcbstx.com](mailto:OCA_SSD@bcbstx.com)**

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:					
<b>Enrollment Records</b>	<b>From:</b>	<b>To:</b>	<b>Claim Records</b>	<b>From:</b>	<b>To:</b>
<input type="checkbox"/> Application/Underwriting/Attending Physician Statement Record	_____	_____	<input type="checkbox"/> Medical	_____	_____
<input type="checkbox"/> Premium Payment/Billing History (if applicable)	_____	_____	<input type="checkbox"/> Dental	_____	_____
			<input type="checkbox"/> Prescription Drugs	_____	_____
			<input type="checkbox"/> Vision	_____	_____
			<input type="checkbox"/> 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 Blue Cross and Blue Shield of Montana 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 Blue Cross and Blue Shield of Montana.			
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)		

Any changes to the format, content or branding of this form are strictly prohibited without review and approval of the HCSC Privacy Office.