



REQUEST TO AMEND PROTECTED HEALTH INFORMATION

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
PO Box 660044
Dallas, TX 75266-0044
OCA_SSD@bcbstx.com

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

First Name _____ Last Name _____ Group Number _____
Social Security Number _____ Date of Birth _____ Identification\Subscriber Number _____
Address _____ City _____ State _____ Zip _____
Area Code & Telephone Number _____ Email Address _____

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:	Health Records	From:	To:
☐ Application/Underwriting/Attending Physician Statement Record	_____	_____	☐ Medical	_____	_____
☐ Premium Payment/Billing History (if applicable)	_____	_____	☐ Dental	_____	_____
			☐ 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 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 Privacy Office.