THE OHIO STATE UNIVERSITY
HEALTH PLAN

Amendment Request Form

You have the right to request that The Ohio State University Health Plan Inc. make corrections or amendments to the personal health information we retain on your behalf if you believe something in that information is in error or needs to be amended. We are not always required to make the corrections or amendments you request, but each request will be carefully reviewed and corrections or amendments made if warranted. You will be notified when your request has been approved or denied. **Complete all applicable sections in order to avoid a delay in processing the application.**

Section I: Member/Dependent Information-All fields are mandatory and should be completed in order for the form to be processed timely. Please Print Clearly & Legibly

Name_____ Date of Birth_____/_____/_____

Address_____ City_____

State and Zip_____ Phone:_____

Trustmark Member ID Number _____

E-mail Address_____

OSU Employee/Subscriber Information

Name_____

Trustmark Member ID Number _____

Section II: Requestor Information (complete if you are not the member)

Name _____

Address_____ City_____

State and Zip_____

Relationship to Member_____ Phone_____

Section III: THIS SECTION MUST BE COMPLETED

Please provide as much detail as possible regarding the correction or amendment you seek in your personal health information. Be as specific as possible regarding the record type, the location, the date and the problem. For instance, "The request for pre-authorization of December 5, 2009 references a laboratory test from ABC laboratory for a blood test that I never received" or "Dr. Jones indicated in the records submitted with a claim on December 5, 2009 that I was suffering from weakness in my right leg when in fact the weakness is in my left leg." **To review the requested correction, we must be able to locate the record at issue and the exact entries or reports you want corrected.**

This form must be accompanied by signature page on the second page of this form.

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Please state precisely as possible how you would like to see the record worded.

If you are aware of anyone else (such as your physician, pharmacist, hospital, etc.) who also may have a copy of the record you seek to have corrected, please list those persons or organizations here with as much information as you have available regarding names and addresses.

I hereby authorize the Ohio State University Health Plan Inc. to notify person/entities I have listed above that may have a copy of the record I seek to have corrected and to provide them with the amended information.

_____ _____
Signature (Digital/electronic signature is not accepted) **Date**

_____
Print Name

If you are a personal representative of a member, please provide documentation or explanation of your authority to act for the member to the back of this form.
Please note that we will not process any requests that are not signed by you or your personal representative. We will not process the form if it contains electronic/digital signature.

For this Amendment Request form to be valid, it must be filled out accurately and completely.

Return this form to the HIPAA Privacy Officer, OSU Health Plan, Inc., 700 Ackerman Road, Suite 1007, Columbus, Ohio 43202 or fax to (614) 292-8366.

FOR OSU HEALTH PLAN PRIVACY OFFICE USE:

APPROVED BY:_____ **DATE:**_____
OSU Health Plan HIPAA Privacy Officer

REASON DENIED:_____

DENIED BY:_____ **DATE:**_____
OSU Health Plan HIPAA Privacy Officer