HIPAA REQUEST TO AMEND PERSONAL HEALTH INFORMATION

This form is for use by West Region beneficiaries or their authorized representative to request amend a beneficiary's PHI contained in the designated record set maintained by TriWest Healthcare Alliance (TriWest) or one of its business associates and amend the PHI if incorrect or incomplete as authorized by the beneficiary or a representative.

SECTION A: Individual/Beneficiary Information

Name:	
Address:	
Telephone:	Email:
Date of Birth:	Social Security Number:
Beneficiary DOD Benefits Number (DBN):	

TO THE BENEFICIARY: Please read the following and complete the information requested.

You have the right to request that TriWest amend your PHI in the designated record set we or business associates maintain.

TriWest will act upon your request within 30 days of receipt of the request. TriWest may deny your request if:

1. TriWest did not create the PHI, unless you provide a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment.
2. TriWest PHI is not part of the designated record set. The designated record set includes your medical and billing records maintained by or for a health care provider; the enrollment, payment, claims adjudication and case or medical management record systems maintained by or for a health plan; or records used whole or in part to make decisions about you.
3. The PHI contains psychotherapy notes; information is compiled for use in a civil, criminal or administrative action; or where applicable law would prohibit TriWest from disclosing the information under HIPAA 164.524.
4. The PHI is accurate and complete.

SECTION B: Amend Request

I request the following information be amended/corrected in my record (What should the entry say to be more accurate or complete?):

SECTION C: Reason for Request

Reason for my request (Please explain why the entry is incorrect or incomplete. Provide additional documentation as needed.):

SECTION D: Notifications

TriWest will notify persons, including business associates, we know to have the PHI that is the subject of the amendment/correction. Would you like this amendment sent to anyone to whom we may have sent the information before it was changed? If so, please specify.

SIGNATURE OF BENEFICIARY OR AUTHORIZED REPRESENTATIVE: Date:
If this request is by a personal representative on behalf of the beneficiary, complete the following:
Personal Representative's Name:
Relationship to Beneficiary:
YOU ARE ENTITLED TO A COPY OF THIS REQUEST.

Please submit the completed and signed request to:
TriWest Healthcare Alliance
Attn: HIPAA Privacy Official
P.O. Box 2585
Virginia Beach, VA 23450
Fax: 877-875-1340