AUTHORIZATION TO AMEND MEMBER INFORMATION

hmsa®

An Independent Licensee of the Blue Cross and Blue Shield Association

ALL SECTIONS MUST BE COMPLETED UNLESS OTHERWISE SPECIFIED

PART A: INFORMATION OF MEMBER REQUESTING AMENDMENT

Last Name	First Name		MI
Address	City	State	ZIP Code
Email	Home Phone # ( )	Cell Phone # ( )	
HMSA Subscriber Number/s (Located on your membership card)		Birth Date _ _ /_ _ /_ _ _ _	

PART B: INFORMATION REQUESTED TO BE AMENDED

1. Please choose the member information you would like HMSA to amend by checking the appropriate box below: (check all that apply)

☐ Claims & Payment
☐ Eligibility & Enrollment
☐ Dues Payment & Billing
☐ Referral & Preauthorization
☐ Medical Records
☐ Appeals
☐ All
☐ Other: _____

2. Please describe the amendment you wish to make:

3. Please state the reasons for requesting this amendment:

4. ☐ Please check this box if you are enclosing supporting documentation and briefly describe the documents.

PART C: PERSON OR ORGANIZATION TO BE NOTIFIED OF AMENDMENT

Last Name	First Name		MI
Street Address	City	State	ZIP Code
Organization (if applicable)	Phone # ( )	Fax # ( )	

(Continued on next page)

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PART D: YOUR INDIVIDUAL RIGHTS

I understand that (**please read**):

- I have the right to request that HMSA amend my protected health information in a designated record set that HMSA or HMSA's business associates maintain.
- HMSA may decline my request if the information is not part of the designated record set; if HMSA did not create the information; if HMSA believes the designated record set is complete and accurate; if the information pertains to psychotherapy notes; if the information is being compiled for use in a civil, criminal, or administrative action or proceeding; or if the information is subject to the Clinical Laboratory Improvements Amendments of 1988 (42 U.S.C 263a, 493.3(a)(2)).
- Upon request, I am entitled to a copy of this signed form.

PART E: SIGNATURE

I, (print member's name) _____, have had full opportunity to read and understand the contents of this form.

Signature: _____ **Date:** _ _ /_ _ /_ _ _ _
(Member or Authorized Representative)

If signed by other than the member or parent of minor child, please print you name below and indicate your relationship. Provide a copy of verification of your legal right (e.g., power of attorney documentation) to make this authorization.

Authorized Representative Name: _____

Relationship to Member: _____

INCOMPLETE FORMS WILL NOT BE PROCESSED
ALL FIELDS ARE REQUIRED UNLESS OTHERWISE SPECIFIED

Please complete, sign, and submit this form to:
HMSA Privacy Office, P.O. Box 860, Honolulu, HI 96808-0860, (fax) 952-7580

(00) 0135-5660 6:16 LE