



## REQUEST TO AMEND A DESIGNATED RECORD SET

Last name \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_

Date of Birth \_\_\_\_\_ Member ID# \_\_\_\_\_ Group# \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

After a review of my record, I do not feel that the original documentation made by \_\_\_\_\_  
\_\_\_\_\_ accurately reflects medical services provided, inquiries made, claims payment,  
or claims denial on the following date: \_\_\_\_\_. I am requesting a correction or addendum to  
\_\_\_\_\_ (identify specific document in question)  
contained in my medical record.

I request that the following correction or amendment be made to my claims and enrollment record:

Please send a copy of the corrected/amended documents to the company or individual listed below:

Name of company or individual \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I understand that PacificSource Health Plans may or may not supplement my record with an addendum based on this request. PacificSource is not allowed to alter the original documentation in my record. My request for amendment and any action taken on this request will become a permanent part of my record and will be included with any future authorized disclosures.

PacificSource will provide a response to this request within 60 days. I can provide a statement of disagreement if PacificSource denies my request. If I am not satisfied with the action taken with respect to this amendment, I can write PacificSource at PO Box 7068, Springfield OR 97475-0068 and report my concerns.

Signature of Member or Representative \_\_\_\_\_

Date \_\_\_\_\_

Printed Name of Representative (if applicable) \_\_\_\_\_

Relationship to Member \_\_\_\_\_

### FOR OFFICE USE ONLY

Date received: \_\_\_\_\_ Sent to: \_\_\_\_\_ Title: \_\_\_\_\_ Date: \_\_\_\_\_

☐ Amendment accepted. Documents or electronic record to be amended: \_\_\_\_\_

☐ Amendment denied. Records are accurate and complete.

☐ Amendment denied. Other reason: \_\_\_\_\_

By \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_

Member notified:

By \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_