REQUEST FOR AMENDMENT OF HEALTH INFORMATION

Please complete this form and return to: Privacy Compliance Administrator
Corporate Compliance, Capital District Physicians' Health Plan, Inc.,
6 Wellness Way, Latham, NY 12110
or Fax: 518-641-5504

I. MEMBER INFORMATION

Date of request: _____ Date of birth:_____

Name:_____

CDPHP Identification #:_____ Telephone Number:_____

II. ADDRESS WHERE CDPHP'S RESPONSE TO YOUR REQUEST SHOULD BE SENT

_____

III. INFORMATION TO BE AMENDED *(Describe the information you would like to be amended)*

_____

Date(s) of information to be amended:_____

How is the entry incorrect or incomplete? _____

What will make the entry more accurate or complete?_____

_____

Do you know of anyone who may have received or relied on the information above (such as your doctor, pharmacist, other health plan or provider)? Yes No

If yes, please specify the name(s) and address(es) of the organization(s) or individual(s):

_____

_____

Do you want the organization(s) or individual(s) you specified above to be notified of your amendment request? Yes No

IV. SIGNATURE

I am requesting the above change in my capacity as *(select one):*

___ Self ___Parent ___Guardian ___Legal Representative *(attach signed authorization form)*

___Other (explain):_____

Signature of member or
legal representative_____ Date_____