Amendment of PHI Request

You have the right to request an amendment to your Protected Health Information (PHI), held by Avēsis, if you feel it is not correct or incomplete. You have the right to request an amendment for as long as the information is kept by Avēsis. You must provide a reason that supports your request.

Avēsis reserves the right to deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by Avēsis, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of a"designated record set" kept by or for Avēsis;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Member Information: (Individual whose information will be released)

Name: _____ Date of Birth: _____
(First, Middle, Last) (Month/Day/Year)

Address: _____
City State Zip Code

Telephone Number: _____
(including area code)

Member ID# or Medicaid ID#: _____

If a member of a Group Plan, provider Subscriber/Employee's Name: _____

Employer Name: _____ Group Plan ID#: _____

Please provide as much detail as possible regarding the correction or amendment you seek to your protected health information. If you require more space than is provided below, please attach additional pages. Be as specific as possible regarding the record type, the location, the date and the problem. For instance, "The request for x-rays related to my dental claim of 3/2/03 was sent to Dr. Jones. It should have been sent to Dr. Watson." or "The address on the Explanation of Benefits dated 3/2/03 was sent to 123 ABC Street. My address at that time was 321 West Haven Street." Such information will assist us in locating the record and information you want corrected. (Please state as precisely as possible how you would like to see the record worded.)

_____

_____

_____

Print Name: _____ Relationship to Member: _____

Signature: _____ Date: _____

If you are an authorized representative (other than a parent of a minor child), you will need to provide documentation or an explanation of your authority to act for the member (e.g., Health Care Power of Attorney).

Please send this form to:

Avēsis, LLC.
Privacy Office
1295 W. Washington Street, Suite 212
Tempe, AZ 85281
privacyoffice@Avesis.com