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# REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

**This form is for subscribers and members covered by the GEHA Health, GEHA Connection Dental Federal, CONNECTION Dental *Plus* plans and/or Connection Vision Plan. Please place a check mark in front of each plan you want this Amendment request to be applied.**

**NOTE: At least one line MUST be checked for this form to be valid.**

GEHA Health Plan (includes Connection Vision Plan)

GEHA Connection Dental Federal Plan (includes Connection Vision Plan)

CONNECTION Dental *Plus* Plan (includes Connection Vision Plan)

CONNECTION Vision Plan only

You have the right to request amendment of your protected health information in a designated record set for as long as the information is maintained in the set, unless law prohibits access to that information.

**NOTE: ALL AREAS OF THIS FORM MUST BE COMPLETED IN FULL. INCOMPLETE FORMS WILL BE CONSIDERED INVALID AND RETURNED.**

**Subscriber/Member Information:**

**Subscriber Name:** ______________________________

**Address:** ______________________________

**Subscriber ID Number:** ____________ **Telephone Number:** ____________

**Patient Name:** ____________ **Date of Birth:** ____________

**Dates of Service:** ____________

**Description of Amendment Desired** ______________________________

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ATTACH COPY OF ALL INFORMATION (i.e. claim, records, etc.) TO BE CONSIDERED FOR AMENDMENT.

GEHA and GEHA's business associates, who partner with us to assist in providing services in areas such as pharmacy, radiology, precertification, vision, etc. (as outlined in GEHA's Notice of Privacy Practices available at www.geha.com) must act on a request for amendment no later than 60 days after the receipt of the request. GEHA and its representatives may take up to 90 days, in which case GEHA will send you a written statement of the reason(s) for the delay and the date by which action will be completed on the request. You will be notified in writing as to acceptance or denial of the request for amendment.

**Date:** ____________

**Patient or Legal Representative Signature:** ______________________________

**Relationship to patient:** ______________________________
(i.e. parent, legal guardian, medical power of attorney, etc.)

**NOTE:** If the signature is not that of the patient or the parent when the child is a minor, appropriate legal documentation is required to accept the signature.

**PLEASE RETAIN A COPY FOR YOUR RECORDS AND RETURN THE ORIGINAL SIGNED FORM TO:**

**GEHA**
**ATTN: Amendment Request**
**P.O. Box 438**
**Independence, MO 64051-0438**
**FAX: 816-257-3283**