

Individual request to correct or amend a record maintained by BlueAdvantage Administrators of Arkansas

Date: _____

Member name	Middle initial	Last name	Member ID	
Address	City		State	ZIP

I request BlueAdvantage Administrators of Arkansas, a third-party claims administrator for my Employer's Group Health Plan, amend the protected health information of _____ in its
(member name)
designated record set within the date range of _____ through _____.
(date in mm/dd/yyyy format) (date in mm/dd/yyyy format)

Specific amendment request

Specific reason for amendment request

I understand that if the protected health information was not created by BlueAdvantage Administrators, then they are not required to honor my request. For example, if the information I wish to amend is a medical report created by my physician, I must ask the physician – not BlueAdvantage Administrators – to amend the report. I also understand that if the information is not available for my inspection, is not part of the plan's designated record set or is already accurate and complete, I cannot amend the information.

I understand that I will receive a written response to my request within 60 days.

Member signature	Date signed (mm/dd/yyyy)
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Submit this completed form to your employer's Human Resources or Benefits Administration Office



BlueAdvantage Administrators of Arkansas

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