Request to Amend Protected Health Information

PRIVACY ACT STATEMENT

This statement serves to inform you of the purpose for collecting personal information required by Health Net Federal Services, LLC (Health Net) on behalf of the TRICARE program, and how it will be used.

AUTHORITY: 10 U.S.C. Chapter 55; 38 U.S.C. Chapter 17; 32 CFR Part 199, and E.O.9397 (SSN), as amended.

PURPOSE: This information allows Health Net to review a beneficiary's PHI contained in the designated record set maintained by Health Net or one of its business associates, and amend the PHI if incorrect or incomplete as authorized by the beneficiary or his or her representative.

ROUTINE USES: Your information may be disclosed in order to investigate waste, fraud and abuse, security, and privacy concerns. Use and disclosure of your records outside of DoD may occur in accordance with the DoD Blanket Routine Uses published at http://dpclo.defense.gov/privacy/SORNs and as permitted by the Privacy Act of 1974, as amended (5 U.S.C. 552a(b)). Any protected health information (PHI) in your records may be used and disclosed as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), and includes purposes of treatment, payment, and health care operations.

DISCLOSURE: Voluntary; if you choose not to provide your information, no penalty may be imposed, but absence of the requested information may result in administrative delays or the inability to process an individual's request.

Please submit the completed request to:

Health Net Federal Services, LLC
Privacy Compliance Office
10730 International Drive
Rancho Cordova, CA 95670
Email: HNFS.Privacy@hnfs.com
Fax number: 844-813-7788

SECTION A: INDIVIDUAL/BENEFICIARY INFORMATION			
Last Name	**First Name**	**Middle Initial**	**Date of Birth (mm/dd/yyyy)**
Address	**City**	**State**	**ZIP Code**
Telephone Number ( )	**Email Address**		
Sponsor Social Security Number (SSN)	**OR**	**Beneficiary DoD Benefits Number (DBN)**	

Please read and complete the following: You have the right to request that Health Net amend your PHI in the designated record set we or business associates maintain.

SECTION B: I request the following information be amended/corrected in my record (What should the entry say to be more accurate or complete?)**:**

SECTION C: Reason for my request (Please explain why the entry is incorrect or incomplete. Provide additional documentation as needed)**:**

SECTION D: NOTIFICATIONS

Health Net will notify persons, including business associates, we know to have the PHI that is the subject of the amendment/ correction. Would you like this amendment sent to anyone to whom we may have sent the information before it was changed? If so, please specify:

Name/Address:_____

Name/Address:_____

Name/Address:_____

If needed, please attach an additional page.

Health Net will act upon your request within 30 days of receipt of the request. Health Net may deny your request if:

1. Health Net did not create the PHI, unless you provide a reasonable basis to believe that the originator of the PHI is no longer available to act on the requested amendment.
2. The PHI is not part of the designated record set. The designated record set includes your medical and billing records maintained by or for a health care provider; the enrollment, payment, claims adjudication and case or medical management record systems maintained by or for a health plan; or records used whole or in part to make decisions about you.
3. The PHI contains psychotherapy notes; information is complied for use in a civil, criminal or administrative action; or where applicable law would prohibit Health Net from disclosing the information under HIPAA 164.524
4. The PHI is accurate and complete.

SECTION E: SIGNATURE

I DECLARE UNDER PENALTY OF PERJURY THE INFORMATION ON THIS FORM OR ATTACHED IS TRUE AND CORRECT. ANY ATTEMPT TO FALSELY GAIN ACCESS TO PHI IS SUBJECT TO LEGAL PENALTIES.

_____ _____

Signature of beneficiary or personal representative* Date (mm/dd/yyyy)

_____

Print name of personal representative

*If this request is signed by a personal representative on behalf of the beneficiary, check the box that describes the relationship to the beneficiary and attach documentation of authority (for example, power of attorney, guardianship, custody documents).

☐ Parent of minor child ☐ Legal guardian ☐ Power of attorney ☐ Executor

Prohibition on redisclosure: Further disclosure of information by the appointed representative may only be made in accordance with the provisions of the Privacy Act of 1974, the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and other applicable federal law.

Please retain a copy of this request for your records.

FOR INTERNAL USE ONLY: (Circle One) APPROVE DENY

Date: _____ Deny reason: _____

Initials: _____ _____

Date forwarded to DHA/TRO: _____