



## Community Health Plan of Washington Request for Correction/Amendment of Protected Health Information

Use this form to request Community Health Plan of Washington (CHPW) correct or amend your protected health information (PHI) that you feel is not correct that CHPW has about you in its designated record set. The designated record set includes records used to make decisions about you as a member. It might also include records about enrollment, claims, plan case management, medical management, or pharmacy information. **(Note:** CHPW cannot change your information if: it was not created by CHPW; it is not part of the designated record set; or it is already correct or complete.)

**1. Member Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Member ID Number:** \_\_\_\_\_ **Date of Request:** \_\_\_\_\_

**Member Address:** \_\_\_\_\_

**Member email:** \_\_\_\_\_

**Member Phone:** \_\_\_\_\_ **Member Fax:** \_\_\_\_\_

**Choose one:**  Ok to leave message with detailed information.  
 Leave message with call-back number only.

**2.** Date of entry or the information to be corrected/amended.

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**3.** Please explain how the entry/information is incorrect or incomplete. What should the entry/information say to be more accurate or complete? (Attach additional sheets to this form if needed.)

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If you agree, CHPW will make a reasonable effort to provide the correction/amendment to other individuals or entities that CHPW knows received the information in the past and who may have relied, or are likely to rely, on such information in a manner that may be detrimental to your health care.

I agree to allow CHPW to release any corrected/amended information to individuals or entities as described above.

4. Would you like the corrected/amended information sent to anyone else who received the information in the past?

Yes       No

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

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5. I understand that the correction/amendment will be completed and I will be notified within 60 days of the date of this request, unless CHPW extends the timeframe for an additional 30 days and provides me with a written statement for the reason(s) for the delay and the date by which I can expect the correction/amendment to be complete.

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<b>Printed Name</b>	<b>Phone</b>	<b>Date</b>
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**Signature**

Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (e.g., Power of Attorney). This only applies if someone other than the member signed above.

**Telephone Number of Personal Representative:** \_\_\_\_\_

**Personal Representative's relationship to the member:** \_\_\_\_\_



**6. Send the completed, signed request to:**

Community Health Plan of Washington  
 Attn: Customer Service Department  
 1111 3<sup>rd</sup> Ave, Ste. 400  
 Seattle, WA 98101  
 Fax: (206) 521-8834  
 Email: [CustomerCare@chpw.org](mailto:CustomerCare@chpw.org)

If you have any questions or to obtain a full notice of your privacy rights, contact CHPW’s Customer Service department at the following

<p><b>If you are a Washington Apple Health (Medicaid) Member</b></p> <p>Contact Customer Service toll-free at 1-800-440-1561, Monday – Friday, from 8am to 5pm.</p> <p>If you are hearing or speech impaired, please call TTY 711 (toll-free).</p> <p>The notice is also available online at: <a href="https://www.chpw.org/for-members/your-privacy-and-rights/">https://www.chpw.org/for-members/your-privacy-and-rights/</a></p>	<p><b>If you are a CHPW Medicare Advantage Member</b></p> <p>Contact Customer Service toll-free at 1-800-942-0247, 7 days a week, from 8am to 8pm.</p> <p>If you are hearing or speech impaired, please call TTY 711 (toll-free).</p> <p>The notice is also available online at: <a href="https://medicare.chpw.org/member-center/member-rights/">https://medicare.chpw.org/member-center/member-rights/</a></p>
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