COMMUNITY HEALTH PLAN of Washington™
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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.

_____

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).

_____

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.

_____ _____ _____

Printed Name **Phone** **Date**

_____

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:

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Community Health Plan of Washington
Attn: Compliance Department
1111 3rd Ave, Ste. 400
Seattle, WA 98101
Fax: (206) 652-7006
Email: member.rights@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

If you are a Washington Apple Health (Medicaid) Member	**If you are a CHPW Medicare Advantage Member**
Contact Customer Service toll-free at 1-800-440-1561, Monday – Friday, from 8am to 5pm. If you are hearing or speech impaired, please call TTY 711 (toll-free). The notice is also available online at: https://www.chpw.org/member-center/member-rights/	Contact Customer Service toll-free at 1-800-942-0247, 7 days a week, from 8am to 8pm. If you are hearing or speech impaired, please call TTY 711 (toll-free). The notice is also available online at: https://medicare.chpw.org/member-center/member-rights/
If you are a Cascade Select Member Contact Customer Service toll-free at 1-866-907-1906, Monday – Friday, from 8:00 a.m. to 5:00 p.m. If you are hearing or speech impaired, please call TTY 711 (toll-free). The notice is also available online at: https://individualandfamily.chpw.org/member-center/member-rights/	