Optum

Request for an Amendment
(Update or Correct Your Healthcare Information)

Complete this form to ask to amend protected health information (PHI) related to services provided by **OptumHealth Care Solutions** (branded as Optum) if you think something is wrong or missing. Please complete each section below. Forms submitted with incomplete information, insufficient legal authority, or signed by the incorrect individual may be denied or result in processing delays.

Optum may deny your amendment request if the PHI that is the subject of the request:

a) Was not created by Optum,
b) Is not part of the Optum Designated Record Set (DRS),
c) Would not be available for inspection (including, but not limited to, exempt items like psychotherapy notes and situations in which the PHI at issue is no longer maintained in the DRS), or
d) Is accurate and complete.

This form should not be used to change your address, phone number or billing information associated with your account. To update account information or for questions about this form, call customer service at the telephone number located on your health plan ID card. You can also change account information by calling your employer group.

For assistance with healthcare information not managed by Optum, contact that entity directly.

Submitting a Request on Behalf of Another Individual

Please have the **member** sign and submit the request if:

1. you are not the legal representative, OR
2. the individual is 12 or older, and the records may relate to sensitive health information, such as mental health, substance use, HIV/AIDs, STD, pregnancy, or reproductive health.

If you qualify as a legal representative, you are required to attach supporting documentation:

- **Power of attorney, Court Order, or another valid document**
- **HIPAA authorizations do not establish legal authority and are not sufficient to submit a request through this process**

Return the completed form via
Fax: 888-371-7011
Mail: Optum Privacy Administrator, 11000 Optum Circle, MN101-E013, Eden Prairie, MN 55344

Section 1: Requestor information & contact details

I am submitting this request for my: ☐ Self ☐ Minor child ☐ Someone else (describe relationship) _____

Preferred contact for questions: ( ) _____ ( ) _____ _____

Home Phone *Cell Phone* *Email Address*

Section 2: Member who this request is being submitted for

_____ _____ _____

First Name *Middle Initial* *Last Name*

( ) _____

Date of Birth *Phone Number*

Address

_____ _____ _____

City *State* *ZIP Code*

Section 3: Subscriber information as it appears on subscriber's health plan ID card

_____ _____ _____

Subscriber Identification Number *Group Number* *Employer*

☐ Check here if the subscriber is the member and information is same as in Section 2 (skip to next section)

_____ _____ _____

First Name *Middle Initial* *Last Name*

( ) _____

Phone Number

Address

_____ _____ _____

City *State* *ZIP Code*

Section 4: Legal representative (Required if requestor is not the member)

_____ _____ ( ) _____

First Name *Last Name* *Phone*

Relationship to member ☐ Parent or legal guardian ☐ *Someone else (describe relationship) _____

**Attach supporting documentation*

Section 5: Amendment Requested

Indicate below what PHI you believe to be inaccurate and/or incomplete and describe the error. If the information relates to a claim, date of service, authorization for treatment, etc., please include specific details such as claim numbers, dates, or other information to help us process your request.

Does someone else have this outdated information and should be notified if we make a change? If so, please complete the contact information below and a paper copy will be mailed to the address provided.

First Name | *Last Name* | *Relationship (e.g., Provider, plan sponsor)*

( )
Phone Number

Address

City | *State* | *ZIP Code*

If you need more space to explain your request, if you have a copy of the information you would like to amend, or if others need to be notified of any changes, provide additional supporting documentation.

Section 6: Select where to receive a response

Send a response to the requestor (member or legal representative) in the following format:

☐ **Option 1:** PDF sent by secure email to the address below (complete if different from Section 1)

Email Address

☐ **Option 2:** Paper copy sent in the mail to the address below (complete if different from Section 2)

Address

City | *State* | *ZIP Code*

Section 7: Member or Legal representative's signature

I authorize the amendment and release (if applicable) of my PHI as identified above.

Member or legal representative's signature ***Date*** *(MM/DD/YYYY)*