HealthSpring℠

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Use this form to request an amendment to your PHI in the Designated Record Set(s) that HealthSpring or its Business Associates maintain. If you need assistance completing the form, please contact the Customer Service number listed on your Member Identification Card. You must complete all the fields on this form.

WHEN COMPLETED AND SIGNED PLEASE MAIL TO YOUR PLAN'S CORRESPONDING ADDRESS BELOW:

Medicare Advantage Plan:
HealthSpring
Medicare Advantage Privacy Rights Intake and Management
PO Box 24207
Nashville, TN 37202

Medicare Prescription Drug Plan:
HealthSpring
Medicare Prescription Drug Plan
PO Box 269005
Weston, FL 33326-9927

Section A The individual for whom amendment is being requested. Please complete the following:

First Name _____ Last Name _____ Group Number _____

Social Security Number _____ Date of Birth _____ Identification\Subscriber Number _____

Address _____ City _____ State _____ Zip _____

Area Code & Telephone Number _____ Email Address _____

Section B Please place an "X" in the box next to the records you are requesting be amended, include specific dates:

Enrollment Records	From:	To:
☐ Application/Underwriting/Attending Physician Statement Record	_____	_____
☐ Premium Payment/Billing History (if applicable)	_____	_____

Health Records	From:	To:
☐ Medical	_____	_____
☐ Dental	_____	_____
☐ Prescription Drugs	_____	_____
☐ Vision	_____	_____
☐ Mental Health	_____	_____

Please state the reason(s) you feel these records should be amended:

_____

Section C Please list the name(s) and address(es) of individuals to notify should we agree to make the amendment.

Name _____ Name _____

Address _____ Address _____

City _____ State _____ Zip _____ City _____ State _____ Zip _____

Section D Signature: This document must be signed by the individual, parent of minor child or the individual's Personal Representative.

I request that HealthSpring amend my PHI as specified in Section B above. I understand that I can only sign on behalf of a minor child under the age of 18, unless there is proof of legal guardianship.

Signature _____ Date: month/day/year _____

Section E If Section D is signed by a Personal Representative, please complete the information below:

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator, please attach a copy of the legal documents. You do **NOT** have to attach copies of these documents if they are already on file with HealthSpring.

Personal Representative's Name _____ Relationship to Individual _____

Personal Representative's Address _____ City _____ State _____ Zip _____

Personal Representative's Area Code & Telephone Number _____

Personal Representative's E-mail Address (if available) _____

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