Amendment Request for Personal Information

Member name: _____ Member ID number: _____

Member address: _____ City, State, Zip_____

Member telephone: _____ Member date of birth: _____

Fallon Health received a request for an amendment to your personal information on _____/_____/_____.

Type of record you want to amend (claim, case management notes, etc.): _____

_____

Information you would like to add/change in the record: _____

_____

Reason for add/change in the record: _____

Dates of record to amend: _____

Do you know of anyone who may have received or relied on the information in question (such as your doctor, pharmacist or health care provider? ☐ Yes ☐ No If yes, please specify the name(s) and address(es) of the organization(s) or individual: _____

_____

I understand Fallon may or may not supplement the medical record with an addendum based on my request, and, under no circumstance, is able to alter the original documentation of the medical record. This request for an addendum may be made part of my permanent record and will be sent to individuals/organizations identified as having relied on the content of my record.

Member (or personal representative) signature: _____

Relationship to member (if personal representative): _____

Print name: _____ Date: _____

Mail completed form to: Fallon Health
1 Mercantile St., Ste. 400
Worcester, MA 01608

FOR FALLON USE ONLY Amendment has been ☐ Accepted ☐ Denied
If denied, check reason for denial:
☐ PHI not created by Fallon
☐ PHI not part of the member's DRS
☐ Federal law does not require the PHI be made available for member inspection (psychotherapy notes, etc.)
☐ PHI is accurate and complete
☐ Fallon cannot comply because we are not the originator, and the requestor cannot show that the originator is not available: _____
Privacy office must review all denials.
☐ Reviewed

Privacy office signature: _____