



ProHealth Care complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex.

ATTENTION: If you do not speak English, language assistance services, free of charge, are available to you. Call 1-262-928-4465 (VRS: 1-866-327-8877).

ATENCIÓN: Si habla español, tenemos a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-262-928-4465 (VRS: 1-866-327-8877).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-262-928-4465 (VRS: 1-866-327-8877).

### **Patient Information**

Name of Patient/Previous Names \_\_\_\_\_

Birth Date \_\_\_\_\_

Medical Record Number \_\_\_\_\_

Street Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone Number \_\_\_\_\_

### **What Needs to be Amended/Corrected and Why**

Date of service & Service Provider: \_\_\_\_\_

Type of record(s) (i.e. history & physical, physician's note, nurse's note, etc.): \_\_\_\_\_

Please explain how the information is incorrect or incomplete, the reasons for this requested change, and what the information should state so that it is more accurate or complete. If more space is needed, please attach an additional page. \_\_\_\_\_

**I understand the following:** The provider may or may not agree to amend the record based on my request. In any event, this request for an amendment will be included as part of my permanent medical record. The provider has 60 days from receipt of this request to respond to it (30 days for mental health records). If this request is for my mental health records, this form will be sent as a part of any release of these records while ProHealth Care reviews the request.

If my request is accepted, I ask that ProHealth Care send a copy of this Amendment Request and ProHealth Care's response to the following organization or individuals listed below. If the previous authorization has already expired, patient will be required to complete a new authorization form.

Name and address of the individual(s)/organization(s):

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

**SIGNATURE OF PATIENT/LEGAL REP:** \_\_\_\_\_ **DATE:** \_\_\_\_\_ **TIME:** \_\_\_\_\_

If signed by a person other than the patient, complete the following:

1. Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
2. Legal authority: ☐ parent\* ☐ legal guardian ☐ next of kin/executor of deceased ☐ activated POA for Health Care

\*By signing above, I hereby declare that I have not been denied physical placement of this minor child.



**Response to Amendment Request**

**Date Received:** \_\_\_\_\_

\_\_\_\_ Your request for an amendment has been APPROVED; a correction/addendum will be made part of your permanent medical record. A copy of the amended document(s) is included.

\_\_\_\_ Part of your request has been approved, please see below for more details. A copy of the amended document(s) is included.

\_\_\_\_ Your request for an amendment has been DENIED; your request has been made part of your permanent medical record.

Your request was denied for the following reason(s):

\_\_\_\_ ProHealth Care did not create the information; please follow up with \_\_\_\_\_

\_\_\_\_ The information is considered accurate and complete

\_\_\_\_ The information is contained in psychotherapy notes

\_\_\_\_ The information is compiled in anticipation of or for use in any civil, criminal or administrative action or proceeding

\_\_\_\_ The original author of the documentation is no longer employed at ProHealth Care

Additional Information:

**Patient Options if Request is Denied**

If your request is denied you may submit a one-page statement of disagreement. The statement will become part of the legal medical record. If copies of the medical records in question are requested, the disagreement letter will be sent along with the copies. The author of the entry may prepare a rebuttal to the statement of disagreement. If he or she does, a copy will be sent to you, and the original will also become part of the legal medical record.

Instead of submitting a statement of disagreement, you may request in writing that this form serves as the statement of disagreement.

**Contact Information:**

HIM Manager/Optum Insight

Supporting ProHealth Care

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Waukesha, WI 53188

262-696-0436