

Request for Amendment of Protected Health Information Form

Use this form to request amendments or corrections to your Protected Health Information, in accordance with the Privacy Regulation enacted by the U.S. Department of Health and Human Services (HHS)

You may submit your request by addressing it to the **Chief Compliance and Privacy Officer of First Medical Health Plan, Inc., PO Box 191580, San Juan, PR 00919-1580**, or by email at cumplimiento@firstmedicalpr.com, by fax at 787-300-3913, or by delivering it directly to any of the First Medical Service Offices.

I. Information of the Beneficiary/Subscriber:					
Number:	Middle Name:	Last Name:			
Postal Address:			Plan Identification Number/Contract Number:		
Primary Phone:	Alternate Phone:	Email: <input type="checkbox"/> I authorize FMHP to send information to my email securely (encrypted)			
II. How can we contact you?					
<input type="checkbox"/> Phone	<input type="checkbox"/> Email	<input type="checkbox"/> Postal Mail	<input type="checkbox"/> TTY	<input type="checkbox"/> Braille	<input type="checkbox"/> Sign Language Interpreter
III. Protected Health Information to Amend or Correct:					
Please explain why the information is incorrect or incomplete. How should the information be stated to be accurate or complete? Use additional sheets if necessary and attach them to this form.					
If you agree, FMHP will make a reasonable effort to provide the amendment to others whom FMHP determines received the information in the past and for whom it may be detrimental to your medical care.					
<input type="checkbox"/> I authorized FMHP to disclose any amended or corrected information to the persons or entities described above.					
IV. Signature					
Signature of Beneficiary/Subscriber:				Date:	
If you are a Legal Representative of the Beneficiary/Subscriber, you must:					
1. Enter your full name: _____					
2. Describe your authority to act for the Beneficiary/Subscriber (e.g.: Power of Attorney, Court Order or Medical Certification): _____					
3. Provide a copy of the legal document naming you as Legal Representative. A Social Security representation document is not acceptable for the purpose of this form (please request assistance from a Customer Service Representative).					
Signature of Legal Representative:				Date:	

For Exclusive Use of FMHP Compliance Department – Privacy Unit

Date Received:

Amendment or correction: Accepted Denied

If denied, specify the reason(s):

If you need additional information, please contact the First Medical Health Plan, Inc., Privacy Unit on 787-474-3999, extensions 2108/2583. We are available Monday through Friday from 8:30am to 5:00pm.

The Customer Service Department offers free language interpreter services and sign language. This includes services in alternate formats such as Braille, large print, and translation to other languages, verbally or written, amongst others. If you need plan information in another format or language, please contact our Customer Service Department at the number on the back of your plan card.

El Departamento de Servicio al Cliente ofrece servicios de intérprete de idiomas y lenguaje de señas libre de costo. Esto incluye, servicio de formatos alternos tales como: Braille, letra agrandada y traducción a otros idiomas, verbal o escrito, entre otros. Si usted necesita información del plan en otro formato o lenguaje, por favor comuníquese con nuestro Departamento de Servicio al Cliente al número que aparece al dorso de su tarjeta del plan.

First Medical *cumple con las leyes federales aplicables de derechos civiles y no discrimina en base a raza, color, origen de nacionalidad, edad, discapacidad, o sexo. First Medical complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex.*

First Medical 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人