



**BlueCross BlueShield
of Illinois**

Request to Amend Protected Health Information (PHI)

Use this form to request an amendment to your Protected Health Information (PHI). Your request will be processed promptly. **If you need assistance in completing this form, please call the Customer Service number listed on the back of your Insurance Identification Card.**

This form must be completed entirely. When complete send to:

**Blue Cross and Blue Shield of Illinois
P.O. Box 805106
Chicago, IL 60680-4112**

Section A: The individual for whom amendment is being requested. Please complete the following:					
Name _____	Group # _____	Identification\Subscriber # _____			
Social Security Number _____	Date of Birth _____				
Address _____	City _____	State _____	ZIP _____		
Area Code & Telephone Number _____	E-mail address (if available) _____			Country _____	

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:	Claim Records	From:	To:
<input type="checkbox"/> Application/Underwriting/Attending	_____	_____	<input type="checkbox"/> Medical	_____	_____
<input type="checkbox"/> Physician Statement Record	_____	_____	<input type="checkbox"/> Dental	_____	_____
<input type="checkbox"/> Premium Payment/Billing History	_____	_____	<input type="checkbox"/> Prescription Drugs	_____	_____
			<input type="checkbox"/> Vision	_____	_____
			<input type="checkbox"/> 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. I understand that should this amendment be approved, Blue Cross and Blue Shield of Illinois will notify the affected Business Associates of the amendment.	
Name _____	Name _____
Address _____	Address _____
City, State, ZIP _____	City, State, ZIP _____

Section D: Signature.	
Signature of Individual or Individual's Personal Representative _____	Date: month/day/year _____

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