COMMUNITY HEALTH NETWORK of Washington™ | Cascade Select

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Community Health Network of Washington
Request for Correction/Amendment of Protected Health Information

Use this form to request Community Health Network of Washington (CHNW) correct or amend your protected health information (PHI) that you feel is not correct that CHNW has about you in its designated record set. The designated record set includes records used to make decisions about you as an enrollee. It might also include records about enrollment, claims, plan case management, medical management, or pharmacy information. (**Note:** CHNW cannot change your information if: it was not created by CHNW; it is not part of the designated record set; or it is already correct or complete.)

1. **Enrollee Name:** _____ **Date of Birth:** _____

Enrollee ID Number: _____ **Date of Request:** _____

Enrollee Address: _____

Enrollee email: _____

Enrollee Phone: _____ **Enrollee Fax:** _____

Choose one: ☐ Ok to leave message with detailed information.
☐ Leave message with call-back number only.

2. Date of entry or the information to be corrected/amended.

_____

3. Please explain how the entry/information is incorrect or incomplete. What should the entry/information say to be more accurate or complete? (Attach additional sheets to this form if needed.)

_____

If you agree, CHNW will make a reasonable effort to provide the correction/amendment to other individuals or entities that CHNW knows received the information in the past and who may have relied, or are likely to rely, on such information in a manner that may be detrimental to your health care.

☐ I agree to allow CHNW to release any corrected/amended information to individuals or entities as described above.

4. Would you like the corrected/amended information sent to anyone else who received the information in the past?

☐ Yes ☐ No

If yes, please specify the name and address of the individual(s) or organization(s).

_____

5. I understand that the correction/amendment will be completed and I will be notified within 60 days of the date of this request, unless CHNW extends the timeframe for an additional 30 days and provides me with a written statement for the reason(s) for the delay and the date by which I can expect the correction/amendment to be complete.

_____ _____ _____

Printed Name **Phone** **Date**

_____

Signature

☐ Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (e.g., Power of Attorney). This only applies if someone other than the enrollee signed above.

Telephone Number of Personal Representative: _____

Personal Representative's relationship to the enrollee: _____

6. Send the completed, signed request to:

Community Health Network of Washington
Attn: Customer Service Department
1111 3rd Ave, Ste. 400
Seattle, WA 98101
Fax: (206) 652-7050
Email: CustomerCare@chpw.org

If you have any questions or to obtain a full notice of your privacy rights, contact CHNW's Customer Service department at the following

Contact Customer Service toll-free at 1-866-907-1906, Monday – Friday, from 8am to 5pm.

If you hare hearing or speech impaired, please call TTY 711 (toll-free).

The notice is also available online at: https://www.cascadeselect.org/member-center/member-rights/