



REQUEST TO AMEND PROTECTED HEALTH INFORMATION (PHI)

You may use this form to request an amendment to your PHI in the Designated Record Set(s) that MotivHealth or its Business Associates maintain. A Designated Record Set is enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or other records that are used, in whole or in part, by or for MotivHealth to make decisions about individuals. If you need help completing this form, please contact our Personal Health Assistants (PHAs) at 844-234-4472.

When completed and signed please mail to: MotivHealth Insurance Company
P.O. Box 7009718
Sandy, UT 84070

You may also email this form to PHA@motivhealth.com or fax this form to: 844-533-1289.

Section I. Please complete the following:					
Name of Member	Group ID#	Member ID#			
Social Security Number	Date of Birth				
Address	City	State	Zip Code		
Telephone Number (XXX-XXX-XXXX)					
Section II. Please place an "X" in the box next to the records you are requesting be amended and include specific dates:					
Enrollment Records	From:	To:	Claim Records	From:	To:
<input type="checkbox"/> Application/Underwriting/ Attending Physician Statement Record			<input type="checkbox"/> Medical		
<input type="checkbox"/> Premium Payment/Billing History (if applicable)			<input type="checkbox"/> Dental		
			<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 III. Please list the name(s) and address(es) of individuals to notify if we agree to amend your PHI.	
Name	Name
Address	Address
City, State, Zip	City, State, Zip
Section IV. Signature- This document must be signed by the Member or the Member's Personal Representative.	
I understand that I can only sign on behalf of a minor child under the age of eighteen (18).	
Signature	Date: month/day/year

Section V. If Section IV is signed by a Personal Representative, please complete the information below.	
If you are signing as a Power of Attorney, Legal Guardian, Executor, or Administrator, please attach a copy of the legal documents.	
Personal Representative's Name	Relationship to Member
Personal Representative's Address	City
Personal Representative's Phone Number	Rep's Email

Any changes to the form must be approved by the privacy officer.
Compliance@motivhealth.com