Request to Amend Protected Health Information (PHI)

motivhealth®

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 for the member accounting being requested:			
Name of Member:	Group:	ID/Subscriber #:	
Social Security #:	Date of Birth:		
Address:	City:	State:	Zip:
Telephone Number:			

Section II. Please check the box next to the records you are requesting be amended and include specific dates.

Enrollment Records:	From:	To:	Claim Records:	From:	To:
☐ Application/Underwriting/ Attending Physician Statement Record ☐ Premium Payment/Billing History (if applicable)			☐ Medical ☐ Dental ☐ Prescription Drugs ☐ Vision ☐ 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:

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:	Representative Email:

Any changes to the form must be approved by the privacy officer: **compliance@motivhealth.com**