



**Request to Correct or Update (Amend) PHI**

(effective 9/2013)

You may request Care1st Health Plan and ONECare by Care1st Health Plan Arizona (Care1st) to correct or add to your record concerning protected health information (PHI). If you believe there is a mistake in your PHI or that important information is missing, please fill out this form and mail it to the address below. Please tell us what you are asking for and why we should make the correction or addition. When you know the facility or your physician’s office, you may request the correction or addition to them. However, if you don’t know where the record that you want is located, please call us at 1-866-560-4042 (TTY 1-800-367-8939).

**VERIFY CURRENT INFORMATION (please print)**

Date of Request: \_\_\_\_\_

Member Name: \_\_\_\_\_

Care 1<sup>st</sup> or ONECare ID#: \_\_\_\_\_

Member Date of Birth: \_\_\_\_\_

Member Phone Number: \_\_\_\_\_

Member Address: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**YOUR REQUEST**

Please specify the health care doctor office (or facility) that has the information you are requesting to correct or update, if request is approved:

\_\_\_\_\_  
\_\_\_\_\_

Please describe the PHI you would like to correct or update (attach additional info if necessary):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Go to next page*

Please describe the dates of service (if known):

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Please explain the reason why your request is necessary:

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**Please note:**

- You may change or revoke (cancel) this request in writing at any time. Please mail your written request to change or revoke to the address below.
- Your request will not be processed if this form is not completely filled out, signed and dated.
- If you do not understand this form, or have any questions about this form, please contact Care1st at: 1-866-560-4042 (TTY 1-800-367-8939).

If you understand the above information, please sign and date below:

\_\_\_\_\_  
Member Signature (or authorized representative,  
or legal guardian)

\_\_\_\_\_  
Date

If you signed and are not the Member, what is your relationship to the member and what is your phone number? Please respond below:

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*Note: Before Care1st can consider a request signed by anyone other than the member, we require verification of a person's authority to act on behalf of the member (if not already on file). If member cannot give consent due to age, Care1st may require additional information before we can consider this request.*

**Return this form to:**

Care1st and ONECare by Care1st Health Plan Arizona

Attn: Privacy Officer

2355 E. Camelback Rd., Ste 300

Phoenix, AZ 85016

**For Care1st use only:**

Received Date: \_\_\_\_\_

Statement of disagreement submitted:  Yes  No

Approve  Deny

Decision:  Amend in full  Deny in full  Amend or deny in part

Notification date of decision: \_\_\_\_\_