meridianhealth

1 Campus Martius, Suite 700
Detroit, MI 48226

888-437-0606
TTY: 711
www.mhplan.com

Dear Member,

Inside is a Request for Amendment of Protected Health Info (PHI) form. You have asked for this form or someone has asked for it on your behalf. This form lets you ask us to change your PHI we keep if there is a mistake. Below are steps to each section on the form. You can use this as a checklist.

SECTION 1: **Your info**

SECTION 2: **Records you want to amend**

SECTION 3: **Changes to be made**

SECTION 4: **Reason for amendment**

SECTION 5: **Who we should notify**

SECTION 6: **Sign and date**

SECTION 7: **Return the form**

- **All sections must be filled out or the form will not be processed**
- **This form does not take effect until Meridian receives it**
- **A response approving or denying your request will be sent to you within 30 days of us receiving this completed form**
- **We will either approve or deny your request. You may have a right to a review of our denial if your request is denied for a reason other than this form not being filled out. We will give you steps for this second review if needed**

Please call Member Services at **888-437-0606** or email **privacy.mi@mhplan.com** if you have questions or need help filling out this form.

REQUEST FOR AMENDMENT OF PHI

This form allows you to request an amendment to your protected health information MeridianHealth (Meridian) maintains. Your request may be declined if the PHI or record(s) that you request to be amended was not created by Meridian, if the PHI or record(s) you request to be amended is complete and accurate or if the PHI or record you request to be amended is not included in the designated record set.

SECTION 1: YOUR INFO			
Name (First and Last):		**Date of Birth (MM/DD/YYYY):**	
Member ID#:		**Phone:**	
Address:	**City:**	**State:**	**Zip:**

SECTION 2: RECORDS YOU WANT TO AMEND

Describe the PHI or which records you want to be amended:

SECTION 3: CHANGES TO BE MADE

Describe the changes to be made:

SECTION 4: REASON FOR AMENDMENT

State the reasons for these changes:

REQUEST FOR AMENDMENT OF PHI

SECTION 5: WHO WE SHOULD NOTIFY			
Name (First and Last):		**Phone:**	
Address:	**City:**	**State:**	**Zip:**

SECTION 6: SIGN AND DATE

Who is signing? ☐ Member listed above ☐ Parent of minor member listed above ☐ Someone other than member*

Signature: _____ **Date:** _____

Name (printed): _____

***Description of authority to act on behalf of the member* (e.g. guardianship, durable power of attorney, court order, parent of minor child, etc.):** _____

You must attach the legal records shown above that name you as the representative of this member. There will be delays in this request if you do not give us this info.

SECTION 7: RETURN THE FORM

Send us a copy of this form by choosing one of the following:

1. **Fax this form to 313-324-9075**
2. **Email this form to privacy.mi@mhplan.com**
3. **Send this form by mail to the address below:**

MeridianHealth
Attn: Privacy Officer
1 Campus Martius, Suite 700
Detroit, MI 48226

meridianhealth

1 Campus Martius, Suite 700
Detroit, MI 48226

888-437-0606
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MeridianHealth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MeridianHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

MeridianHealth:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Meridian's Grievance Coordinator.

If you believe that MeridianHealth has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Meridian's Grievance Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Meridian's Grievance Coordinator is available to help you.

Mail:	MeridianHealth Attn: Grievance Coordinator P.O. Box 44287 Detroit, MI 48244
Telephone:	888-437-0606 (TTY users should call 711)
Fax:	313-463-5259
Email:	medicaidgrievances@mhplan.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-437-0606 (TTY: 711).

العربية (Arabic): ملحوظة: إذا كنت تتحدث العربية، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 888-437-0606 (رقم هاتف الصم والبكم: 711).

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 888-437-0606 (TTY: 711)。

Tagalog (Tagalog-Filipino): PAUNAWA: Kung nagsasalita kayo ng Tagalog, maaari kayong gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 888-437-0606 (TTY: 711).

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu quý vị nói Tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 888-437-0606 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 888-437-0606 (TTY: 711).

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 888-437-0606 (TTY: 711)로 전화해 주십시오.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 888-437-0606 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 888-437-0606 (TTY: 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 888-437-0606 (TTY: 711).

Shqip (Albanian): KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 888-437-0606 (TTY: 711).

বাংলা (Bengali): **লক্ষ্য করুন: যদি আপনি বাংলা ভাষায় কথা বলেন, তাহলে ভাষা সহায়তা পরিষেবা নিঃখরচায় উপলব্ধ আছে। ফোন করুন** 888-437-0606 (TTY: 711)।

日本語 **(Japanese)**: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。888-437-0606 (TTY: 711) まで、お電話にてご連絡ください。

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 888-437-0606 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

ܐܬܘܪܝܐ (Assyrian):: ܙܘܗܪܐ: ܐܢ ܐܢܬ ܟܐ ܡܗܡܙܡܬ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܐܝܬ ܠܘܟ ܕܡܫܬܡܫܬ ܒܚܠܡܬܝܐ ܕܗܝܪܢܘܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܝ ܥܠ ܡܢܝܢܐ 888-437-0606 (TTY: 711)