STATE OF LOUISIANA
DIVISION OF ADMINISTRATION
OFFICE OF GROUP BENEFITS

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

I hereby request an amendment to the information maintained in the records held by the Office of Group Benefits (OGB).

Health plan member/dependent name: ______________________________

Member ID number: ______________________________

Date of Birth: ______________________________

Address: ______________________________

Primary Phone Number: ________________ Alternate Phone Number: ________________

Date of entry to be amended:

Date: ____________________ Date: ____________________

Type of entry to be amended:

Entry: ____________________ Date:

Please explain how the entry is incorrect or incomplete. Please indicate what the entry should state to be accurate or complete.

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Please indicate if the amendment should be sent to anyone to whom we may have disclosed information in the past. Please include the name and address of the individual.

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Signature of Health Plan Member/Dependent or Representative Date

Request is (circle one): Approved Denied

Comments of the OGB Reviewer:

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Signature of the OGB Reviewer Date