



**HIPAA AMENDMENT REQUEST**

**Purpose:** This form is for use by the TRICARE beneficiary or the beneficiary’s authorized representative to request the amendment of protected health information in TriWest’s designated record set or the designated record set maintained for TriWest by one of its business associates.

**SECTION A: BENEFICIARY REQUESTING AMENDMENT**

Name:			
Address:			
Telephone:	(    )	E-mail:	
Social Security Number:	Sponsor:	- -	Beneficiary:

**TO THE BENEFICIARY:** Please read the following and complete the information requested.

You have the right to request us to amend your protected health information in our designated record sets. We may decline your request if the information is not part of our designated record sets, we did not create the information, we believe the information is complete and accurate, and for certain other reasons. To exercise your right to request an amendment, please complete SECTION B.

**SECTION B: PROTECTED HEALTH INFORMATION TO BE AMENDED**

Please specify the records you wish to have amended and the amendment you wish to make:

Please state the reason for the requested amendment:

**BENEFICIARY’S SIGNATURE:** \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

If this request is by a personal representative on behalf of the beneficiary, complete the following:

Personal Representative’s Name: \_\_\_\_\_

Relationship to Beneficiary: \_\_\_\_\_

**YOU ARE ENTITLED TO A COPY OF THIS REQUEST**

Please submit the completed and signed request to: TriWest Healthcare Alliance; Attn: HIPAA Privacy Official; P.O. Box 42049; Phoenix, AZ 85080-2049