Group Insurance Trust of the
California Society of Certified Public Accountants
Request for Amendment

Please provide the information below. We cannot respond to your request without this information.

Your name: ____

Employee's name: ____ Employee's ID: ___________________

Use this form to request an amendment of inaccurate or incomplete health information maintained by the Health Plans and used to make decisions about your Health Plan benefits. Be as specific as possible in your description of the incorrect information. **If you have evidence to support your request, please submit it with this form.** Please note that the Health Plans may not amend health information that was originally created by another entity (for example, a medical record sent by your physician). If the incorrect information was created by another entity, you should make your request for amendment directly to that entity.

Describe the inaccurate or incomplete health information:

___

___

___

Describe the proposed amendment to your health information:

___

___

___

Apply this request to the following Health Plans:

- ❑ ProtectPlus Medical Plans (PPO)
- ❑ CaliforniaCare Medical Plan (HMO)
- ❑ Vision Service Plan (Vision Plan)
- ❑ Managed Health Network (Mental Health)
- ❑ Delta Dental (Dental Plan)
- ❑ Other

List the names and contact information for any third parties who should be informed of the amendment. By listing these third parties, you agree to allow the Health Plans to share your requested amendment with these third parties if your request is accepted:

____________________________ ____________________________ ____________________________

____________________________ ____________________________ ____________________________

____________________________ ____________________________ ____________________________

The Health Plans will notify you if your request to amend your health information is accepted. Notice of the amendment will be provided to the third parties you have identified above.

For internal use only:

❑ Approved Notice of extension sent: ____________________________________

❑ Denied Date received: ___________________________ Response Date: _______________________

Include with future disclosures? ❑ Yes ❑ No Amendment Date: ______________________

Policy Attachment _________ 10452739