



## Request for Correction/Amendment of Protected Health Information

Member name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Subscriber number: (9-digit) \_\_\_\_\_

Member address: \_\_\_\_\_

Member phone number: \_\_\_\_\_

Date of entry to be amended: \_\_\_\_\_ Type of entry to be amended:  Address amendment  Claims history

Please explain how the entry is incorrect or incomplete. What should the entry say to be more accurate or complete?

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

Would you like this amendment sent to anyone to whom we may have disclosed the information in the past? If so, please specify the name and address of the organization or individual.

Name: \_\_\_\_\_ Address: \_\_\_\_\_

Name: \_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_  
Signature of member or legal representative Date

### For Delta Dental use only:

Date received \_\_\_\_\_ Amendment has been:  Accepted  Denied

If denied, check reason for denial:  PHI is not available to the patient for inspection required by federal law

PHI was not created by Delta Dental  PHI is not part of patient's designated record set  PHI is accurate and complete

Comments of dental provider: \_\_\_\_\_

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

\_\_\_\_\_  
Name of staff member Title

\_\_\_\_\_  
Signature of dental provider Date

Direct correspondence to: Privacy Office, Delta Dental of Michigan, P.O. Box 30416, Lansing, MI 48909-7916.