



## STATE OF LOUISIANA - 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). I understand that OGB may deny my request for amendment in accordance with 45 C.F.R. §164.526(a)(b).**

MEMBER/DEPENDENT NAME	DATE OF BIRTH	MEMBER ID NUMBER OR LAST 4 DIGITS OF SSN	
ADDRESS	CITY	STATE	ZIP CODE
EMAIL ADDRESS	TELEPHONE (PRIMARY)	TELEPHONE (ALTERNATE)	
DATE OF ENTRY TO BE AMENDED	TYPE OF ENTRY TO BE AMENDED		
PLEASE EXPLAIN HOW THE ENTRY IS INCORRECT OR INCOMPLETE. PLEASE INDICATE WHAT THE ENTRY SHOULD STATE TO BE ACCURATE.			
PLEASE INDICATE IF THE AMENDMENT SHOULD BE SENT TO ANYONE TO WHOM WE MAY HAVE DISCLOSED INFORMATION IN THE PAST. PLEASE INDICATE THE NAME AND ADDRESS OF THE INDIVIDUAL.			

\_\_\_\_\_  
SIGNATURE OF HEALTH PLAN MEMBER/DEPENDENT OR REPRESENTATIVE

\_\_\_\_\_  
DATE

Request is (circle one):

APPROVED

DENIED

COMMENTS OF THE OGB REVIEWER:

\_\_\_\_\_  
SIGNATURE OF OGB REVIEWER

\_\_\_\_\_  
DATE