State of Louisiana, Office of Group Benefits
Request for Amendment of Protected Health Information

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

Health Plan Member/Dependent Name: _____

Date of birth: _____ **Telephone:** _____

Address: _____

_____

Member Number: _____

Date of entry to be amended:
Date _____ Date _____

Type of entry to be amended:
Entry _____Entry _____

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

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 or organization.

Signed: _____ Date: _____
Signature of Health Plan Member/Dependent
or Representative

Request is (circle one): Approved Denied

Comments of the OGB Reviewer:

Signed: _____ Date: _____
Signature of the OGB Reviewer