WPS HEALTH SOLUTIONS | WPS HEALTH INSURANCE | Arise HEALTH PLAN | EPIC SPECIALTY BENEFITS

REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

You have the right to request that protected health information about you that is maintained by Wisconsin Physicians Services Insurance Corporation (WPS or WPS Health Insurance), and/or its wholly owned subsidiaries, The EPIC Life Insurance Company (EPIC Specialty Benefits), and WPS Health Plan, Inc. (Arise Health Plan) (hereinafter "WPS Health Solutions") be amended if you believe it is incorrect or incomplete. We will review your request and will either grant it or explain the reason why the request will not be granted no later than thirty days from receipt of your request. If your request is not granted, you will have the right to submit a statement of disagreement that will accompany future disclosures of the information by WPS Health Solutions. ***NOTE: WPS Health Solutions does not maintain original medical records. We advise members to contact their provider's office, clinic or hospital to obtain medical records. Members must follow the provider's procedures for amending medical records.**

PART A: MEMBER INFORMATION

Member Last Name	Member First Name	M. I.	Member Date of Birth

Member Street Address	City	State	Zip Code

Phone # (including area code)	Cell Phone# (including area code)	Subscriber Number (ID Card)

***** Complete the following only if the person making the request is not the member *****

Name of Requestor	Relationship to member	Legal Authority

Address	Phone Number

PART B: REQUEST FOR AMENDMENT OF PROTECTED HEALTH INFORMATION

You have the right to request WPS Health Solutions amend your PHI. We may decline your request for reasons such as we did not create the information, or we believe the information is complete and accurate. To exercise your right to request amendment, please complete this Section.

I request amendment of the following specific protected health information about me held by WPS Health Solutions: (*please specify the records you with to have amended*)

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I believe that the information described above is incorrect or incomplete for the following reason(s):

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I hereby request that the information identified above be amended as follows (*please specify how the entry should be changed to be correct or more complete*):

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PART C: MEMBER SIGNATURE OR AUTHORIZED REPRESENTATIVE/GUARDIAN

Member signature or Designated Legal Representative/Guardian signature **X**	**Date**

If authorized representative: (1) print your name, (2) state the legal authority for your status as Member's representative, and (3) attach supporting documentation:

FOR STAFF USE ONLY

This request was reviewed on ______________ (Date) by ____________________________________ (Name and Title).

☐ The request was approved and the amendment described above was appended to the record.

☐ The request was approved in part: Explanation attached.

☐ The request was denied: Denial of Amendment is attached.

Email: WPSprivacyofficer@wpsic.com **Mail:** Legal/Privacy, P.O. Box 8190, Madison, WI 53708-8190 **Fax:** (608) 977- 9885

20927-009-1605