

Member Request to Amend a Designated Record Set

If you have questions, please contact Customer Service at 503-574-7500 (toll-free 1-800-878-4445; TTY 711)

MEMBER INFORMATION					
MEMBER LAST NAME	MEMBER	MEMBER FIRST NAME		MEMBER MIDDLE NAME	
DATE OF BIRTH	MEMBER	ID#	GROUP ID#	ŧ	
// STREET ADDRESS					
STREET ADDRESS					
CITY STATE		ZIP CODE		PHONE NUMBER	
	Olivite	211 0002		THORE NOMBER	
After review of my record, I do not feel that original documentation made by					
accurately reflects medical services provided, inquires made, claims payment or denied on the following date (/_ /). I					
am requesting a correction or addendum to(identify specific document					
in question) contained in my medical record.					
I request the following correction/amendment be made to my claims and enrollment record.					
Trequest the following correction/amendment be made to my claims and emoliment record.					
Please send a copy of the corrected/amended documents to the company or individual listed below:					
Company: Name:					
Address:		City:		State:Zip:	
I understand that Providence Health Plans (PHP) may or may not supplement my record with an addendum based on this request. PHP is not allowed to alter the original documentation in my record. My request for amendment and any action taken on this request, will become a permanent part of my record, and will be included with any future authorized disclosures.					
PHP will provide a response to this request within sixty days. I can provide a statement of disagreement if PHP denies my request. If I am not satisfied with the action taken with respect to this amendment process, I can write PHP at PO Box 4327, Portland, OR 97208-4327 and report my concerns.					
Please sign and date:					
Member or Representative's signat	ure	Date			
Printed Name of Representative (if	applicable)	Relationship to Member			
FOR OFFICE USE ONLY					
Date received:	Sent to:		Title:	Date:	
Amendment Accepted					
☐ Denied: Records are Accurat ☐ Denied: Other (state reason					
By:				Date:	
Member notified:					
By:		Title [.]		Date:	
-1.					

Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
 - o Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you are a member who needs these services, please call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan

Attn: Non-discrimination Coordinator

PO Box 4158

Portland, OR 97208-4158

If you need help filing a grievance, you can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200 Independence Avenue SW - Room 509F HHH Building Washington, DC 20201 1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

注意:如果您使用繁體中文,您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項:日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 4445-878-800-1 (رقم هاتف الصم والبكم: (TTY: 711).

ATENŢIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

878-4445-878 ن ماس دیری بگ. شمای براگان ی را به صورت ی زبان لاتی ت سهد،ی کن ی م گفت گوی فارس زبان بهاگر : توجه فی م با شد . با (TTY: 711)

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).

เรียน: ถ้าคุณพูคภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)

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