OPTUM®

REQUEST TO AMEND PROTECTED HEALTH INFORMATION

You have a right to change or amend personal information about you that Optum® Specialty Pharmacy keeps. The Health Insurance Portability and Accountability Act calls this protected health information (PHI). PHI includes order information and other records that we use to make decisions about the services you receive.

Use this form to request that Optum Specialty Pharmacy change or correct information we have about you that you believe is wrong or inaccurate. For example, an order for a medication that was not prescribed to you, but is in our records.

You can only request to correct or update your own PHI, unless you are authorized to amend information about someone else.

Optum Specialty Pharmacy will respond to requests submitted by your authorized representative, such as a parent, court-appointed representative or other family member, provided you have authorized Optum Specialty Pharmacy to disclose PHI to your authorized representative. However, we may ask for more information from you or your authorized representative to verify the right to act on your behalf.

Please note: We will amend only PHI relating to services provided by Optum Specialty Pharmacy. For questions relating to other services, please contact your health or prescription benefit plan directly.

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REQUEST TO AMEND PROTECTED HEALTH INFORMATION

Use this form to amend or change protected health information (PHI) maintained by Optum Specialty Pharmacy. When filling out this form, please complete all sections, print information clearly, provide your most current information and state what information we have about you that you believe to be wrong/incomplete and want to correct. Once we make a decision about your request, we will send you or your authorized representative a letter explaining the decision.

1 Member information (please provide current information)

Last Name | First Name | MI

Mailing Street Address | Apt. #

City | State | ZIP

Date of Birth (mm/dd/yyyy) | Gender ○ M ○ F | Phone Number with Area Code

2 Amendment requested

Please indicate what PHI you believe to be inaccurate and/or incomplete and describe the error. If the information relates to a home delivery prescription order, date of service, medication, etc., please include the order numbers, dates or other information that will help us process your request. Please attach a copy of the information you would like to amend.

If someone else also has this outdated information and should be notified if we make a change, please provide contact information below:

Name | Relationship (e.g., Provider, Plan Sponsor, etc.)

Address | City | State | ZIP

Name | Relationship (e.g., Provider, Plan Sponsor, etc.)

Address | City | State | ZIP

3 Member/authorized representative signature

I authorize the amendment of the stated protected health information for others as directed in a signed authorization; or to others legally authorized to act on my behalf, to request an amendment of the stated PHI.

X _____ _____
Member Signature | Date

X _____ _____
Authorized Representative Signature (if applicable) | Date

Important: If legal documentation is not on file with Optum Specialty Pharmacy, the authorized representative, including the parent, legal guardian, or executor of an estate, must attach a copy of legal documentation to this form.

Authorized Representative's Name | Phone Number with Area Code

Mailing Street Address | Apt. #

City | State | ZIP

Relationship to Member and Authority to Act for Member

4 Please mail the completed form to: Optum Specialty Pharmacy, Privacy Office, 2300 Main Street, Mail Stop: CA134-0304, Irvine, CA 92614