



APWU Health Plan Request for Amendment to Protected Health Information

Requestor Name: _____

Member Name: _____

Patient Name: _____
(If different from Requestor)

Member ID Number: _____

Mail to Address: _____

I am requesting an amendment to my protected health information maintained by the APWU Health Plan and its Business Associates.

Information to be amended and how it is to be amended (be as specific as possible):

I understand that the APWU Health Plan does not, by law, have to agree to my requested amendment. I understand that I will receive a response to or be given the status of my request within sixty (60) days from the APWU Health Plan's receipt of the request.

Signature of Requestor

Date

Relationship to Patient
(Attach valid authorization to act on Patient's behalf)

Please send to:

APWU Health Plan
Privacy Specialist
799 Cromwell Park Drive
Glen Burnie, MD 21061
1-800-222-2798

