



BlueCross BlueShield of New Mexico

Member PHI Amendment Request Response Form

(Use this form if you do not agree with BCBSNM's response to your PHI amendment request.)

Blue Cross and Blue Shield of New Mexico (BCBSNM) recently received your request to amend (change) your Protected Health Information (PHI). BCBSNM was unable to process this request. Use the form below if you do not agree with our decision. You may also use this form to request that your original amendment request and BCBSNM's response letter be attached to future disclosures of your PHI. If you need help completing this form, please contact Blue Cross Community CentennialSM Member Services at 1-866-689-1523 (TTY: 711). You must complete all the fields on this form.

You received a letter from BCBSNM in response to your PHI amendment request. Please include that letter with this form.

WHEN COMPLETED AND SIGNED, PLEASE MAIL TO: Blue Cross and Blue Shield of New Mexico
P.O. Box 660044
Dallas, TX 75266-0044

Or email to: OCA_SSD@bcbst.com

Section A: The Member for whom the amendment was unable to be processed. Please complete the following:

Name _____		Group # _____	Identification\Subscriber # _____	
Social Security Number _____	Date of Birth _____			
Address _____	City _____	State _____	ZIP _____	
Area Code & Telephone Number _____		E-mail Address (if available) _____		

Section B: Please select the appropriate option. You may select only one:

- Option 1:** I request that you attach the Statement of Disagreement below to my Designated Record Set (health records).
(Please limit your statement to the space provided below.)

- Option 2:** I do not choose to submit a Statement of Disagreement. Instead, I request that you include my original request for amendment and BCBSNM's response letter with any future disclosures of the PHI that I requested be amended.

Section C: Signature. This document must be signed by the Member, parent of a minor child, or the Member's authorized representative.

I understand that I can only sign on behalf of a minor child under the age of 18, unless there is proof of legal guardianship.

Signature

Date (Month/Day/Year)

Section D: If Section C is signed by an authorized representative, please complete the information below:

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator, please attach a copy of the legal documents. You do **NOT** have to attach copies of these documents if they are already on file with Blue Cross and Blue Shield of New Mexico.

Authorized Representative's Name

Relationship to Individual

Authorized Representative's Address

City

State

ZIP

Authorized Representative's Address

Authorized Representative's E-mail Address
(if available)

To ask for auxiliary aids and services or materials in other formats and languages at no cost, please call **1-866-689-1523** (TTY/TDD: **711**).

Blue Cross and Blue Shield of New Mexico complies with applicable federal civil rights laws and does not discriminate on the basis of health status or need for services or race, color, national origin, age, disability, sex, ancestry, spousal affiliation, sexual orientation and/or gender identity. Blue Cross and Blue Shield of New Mexico does not exclude people or treat them differently because of health status or need for services or race, color, national origin, age, disability, sex, ancestry, spousal affiliation, sexual orientation and/or gender identity.

Blue Cross and Blue Shield of New Mexico provides:

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

If you need these services, contact the Civil Rights Coordinator.

If you believe that Blue Cross and Blue Shield of New Mexico has failed to provide these services or discriminated in another way on the basis of health status or need for services or race, color, national origin, age, disability, sex, ancestry, spousal affiliation, sexual orientation and/or gender identity, you can file a grievance with: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35th floor, Chicago, Illinois 60601, **1-855-664-7270**, TTY/TDD: **1-855-661-6965** or Fax: **1-855-661-6960**. You can file a grievance in person, by mail or fax. If you need help filing a grievance, a Civil Rights Coordinator is available to help you.

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, D.C. 20201

1-800-368-1019, 1-800-537-7697 (TDD)

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

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-710-6984 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-710-6984 (TTY: 711).

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'déé', t'áá jiik'eh, éí ná hóló, kojí' hódííłnih 1-855-710-6984 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-710-6984 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-710-6984 (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 1-855-710-6984 (TTY: 711)。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-710-6984 (رقم هاتف الصم والبكم: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-710-6984 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-710-6984 (TTY: 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。1-855-710-6984 (TTY: 711) まで、お電話にてご連絡ください。

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-710-6984 (ATS: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-710-6984 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-710-6984 (телетайп: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।

1-855-710-6984 (TTY: 711) पर कॉल करें।

هجوٲ: رگا هب نابز سرافى وگتفگ مى دینک، تلايهست نابزى هب تروص ناگیار اربى امش مهارف مى دشاب. اب 1-855-710-6984 (TTY: 711) سامت دیریگب.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-710-6984 (TTY: 711).