Blue Cross Community Health Plans℠

c/o Member Services
P.O Box 3418
Scranton, PA 18505

Denied Amendment Response

Use this form to ask that your original denied amendment request be attached to future disclosures of Protected Health Information (PHI). If you need help completing the form, please contact the Customer Service number listed on the back of your Member Identification Card. You must complete all the fields on this form.

We will need a copy of our original denial letter in order to respond to this request.

WHEN COMPLETED AND SIGNED PLEASE MAIL TO: **c/o Privacy Office**

Blue Cross Community Health Plans
P.O. Box 805106
Chicago, IL 60680-4112

Section A: The individual for whom amendment was denied. 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 following Statement of Disagreement to my Designated Record Set. (Please limit your response to the space provided below.)

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☐ **Option 2**: I do not choose to submit a Statement of Disagreement. Instead, I request that you include my original Request for Amendment and subsequent denial with any future disclosures of the PHI that I requested be amended.

Section C: Signature - This document must be signed by the individual, parent of a minor child or the individual's Personal Representative.
I understand that I can only sign on behalf of a minor child under the age 18, unless there is proof of legal guardianship. ____________________ ____________________ **Signature** **Date: month/day/year**

Section D: If Section C is signed by a Personal 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 Community Health Plans **Personal Representative's Name** **Relationship to Individual** **Personal Representative's Address** **City** **State** **ZIP** **Personal Representative's Area Code & Telephone Number** **Personal Representative's E-mail address (if available)**

If you have any questions, please call Member Services at **1-877-860-2837** (TTY/TDD **711**). We are available 24 hours a day, seven (7) days a week. The call is free.

Blue Cross Community Health Plans is provided by Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association.

To ask for supportive aids and services, or materials in other formats and languages for free, please call, 1-877-860-2837 TTY/TDD:711.

Blue Cross and Blue Shield of Illinois complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross and Blue Shield of Illinois does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Illinois:

- 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, other formats)
- Provides 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 Civil Rights Coordinator.

If you believe that Blue Cross and Blue Shield of Illinois 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: 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, Fax: 1-855-661-6960, Civilrightscoordinator@hcsc.net. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, 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, 800-537-7697 (TDD)

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

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-877-860-2837 (TTY/TDD: 711)**.

Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-860-2837 (TTY/TDD: 711)**.

繁體中文 (Chinese): 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 **1-877-860-2837 (TTY/TDD: 711)**.

Tagalog (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-860-2837 (TTY/TDD: 711)**.

Français (French): ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-877-860-2837 (ATS : 711).**

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-860-2837 (TTY/TDD: 711)**.

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-860-2837 (TTY/TDD: 711)**.

한국어 (Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-860-2837 (TTY/TDD: 711)**번으로 전화해 주십시오.

Русский (Russian): ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-860-2837 (телетайп: 711)**.

عربي (Arabic):
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-860-2837** (رقم هاتف الصم والبكم: 711).

हिंदी (Hindi): ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-877-860-2837 (TTY/TDD: 711)** पर कॉल करें।

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-877-860-2837 (TTY/TDD: 711)**.

ગુજરાતી (Gujarati): સૂચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-877-860-2837 (TTY/TDD: 711)**.

اُردُو (Urdu): خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں **1-877-860-2837 (TTY/TDD: 711)**.

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-877-860-2837 (TTY/TDD: 711)**.

λληνικά (Greek): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-877-860-2837 (TTY/TDD: 711)**.