Michigan Conference of Teamsters Welfare Fund
Individual Request to Amend Protected Health Information

Section #1: Individual Information

Name _____ Birth Date _____/_____/_____
Please Print MM / DD / YR

Contract Number _____ or Social Security Number _____
(Found on ID card)

Address _____

City _____ State _____ ZIP Code _____

Telephone Number _____ E-mail _____

Section #2: Request for Amendment

I hereby request an amendment to the health information (information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996) for the identified individual identified in Section #1. I understand that the Michigan Conference of Teamsters Welfare Fund (the Fund) **may not** grant this request for amendment if the information: 1) was not created by the Fund; 2) is accurate and complete; 3) is not part of the record requested for amendment; and/or, 4) includes information that I am not permitted to change.

Please make the following amendment(s) to the health information for the individual identified in Section #1 as described: (Note: Attach copies of documentation to support claim for amendment.)

_____
_____
_____
_____
_____
_____
_____
_____

I request that the amendment(s) as described be made to the health information contained in the following records (check all that apply):

☐ enrollment ☐ self-contribution payment

☐ medical documentation relating to the following service or claim determination: (specify service and/or medical condition) _____

_____

☐ claims detail and EOB information relating to the following service or claim: (specify date of service and/or medical condition)

_____
_____

☐ other (please specify) _____

Section #3: Authorization and Signature

I, _____ (print name), have reviewed this form and understand its contents. By signing this form, I am confirming that it accurately reflects my wishes.

_____ Date of Signature _____/_____/_____
Signature MM / DD / YR

Address_____

City _____ State _____ ZIP Code _____

☐ I am the personal representative for the member.*

**Note: If you are a personal representative of the individual and you are completing this form on behalf of the individual, you must complete Section #4. Personal representative means a person with legal authority (under State or applicable law) to act on behalf of the individual in making health care decisions.*

Section #4: Personal Representative

If signed by a personal representative, complete the following:

Name of personal representative: _____
(print name)

Name of individual you are representing: _____
(print name)

Relationship to individual or nature of authority (e.g., health care power of attorney, guardian, other statutory authorization):

_____*Note: If other than natural parent of a minor child, valid and current proof of legal relationship as personal representative must be provided.*

Personal Representative Contact Information

Address: _____ Telephone Number: _____

_____ E-mail: _____

_____ Date of Signature _____/_____/_____
Signature of Personal Representative MM / DD / YR

Submit Form to: ***Privacy Officer***
Michigan Conference of Teamsters Welfare Fund
2700 Trumbull Avenue
Detroit, MI 48216

Or Fax to: ***313-496-2943***