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Missouri Consolidated Health Care Plan
573-751-0771 · 800-487-0771 · www.mchcp.org
832 Weathered Rock Court, Jefferson City, MO 65101

Member Record Amendment/Correction

State Members

Submit this form:
Online: Upload through myMCHCP
Fax: 866-346-8785
Mail: PO Box 104355
Jefferson City, MO 65110-4355

MCHCP Use Only

ST MRAC

Please print clearly

Instructions

If you need assistance in completing this form, please contact MCHCP at 800-487-0771

Section 1 – Member Information

Member Name (Person whose record needs to be amended or corrected):

_____

Address:

_____

City: **State**: **ZIP Code**:

_____ _____ ___ ___ ___ ___ ___

Primary Phone Number: ❑ Home ❑ Work ❑ Mobile
(___ ___ ___) ___ ___ ___ – ___ ___ ___ ___

Secondary Phone Number: ❑ Home ❑ Work ❑ Mobile
(___ ___ ___) ___ ___ ___ – ___ ___ ___ ___

MCHCPid (Provide **either** MCHCPid or Social Security Number)
___ ___ ___ ___ ___ – ___ ___ ___ ___ ___

or **Social Security Number**:
___ ___ ___ – ___ ___ – ___ ___ ___ ___

Section 2 – Record Amendment/Correction

1. Date of Member Record Entry to be Corrected:

_____

2. Member Record Language to be Amended/Corrected:

_____

3. Amendment/Correction:

_____

4. Reason for Amendment/Correction:

_____

Section 3 – Information Recipients & Authorization

Identify entities that have received the information:

Person or Organization/Address	**Phone Number**
_____	(___ ___ ___) ___ ___ ___ – ___ ___ ___ ___
_____	(___ ___ ___) ___ ___ ___ – ___ ___ ___ ___
_____	(___ ___ ___) ___ ___ ___ – ___ ___ ___ ___

Do you authorize MCHCP to provide the information in item Nos. 3 and 4 in Section 2 to the persons and/or organizations listed above?

❑ YES ❑ NO, do not provide the information to: _____

You have the right to submit a Member Record Amendment/Correction form to be made a part of your member record. This right does not permit you to alter or change the original record created by MCHCP, your health plan, or your health care provider and staff. MCHCP may deny your request to amend or correct your records.

Signature of Member:

_____

Date (MM/DD/YYYY):
___ ___/ ___ ___/ ___ ___ ___ ___

MCHCP STAFF ONLY

Amendment/Correction

❑ ACCEPTED ❑ DENIED, please explain: _____

This Amendment/Correction Sheet is to be made a part of the medical record of: (Member Name):

_____

- If MCHCP denies your requested amendment/correction, you have the right to submit a written statement disagreeing with the denial and your reason for disagreement. MCHCP may reasonably limit the length of your written statement, and MCHCP may prepare a rebuttal to your written statement of disagreement (and provide you with a copy).
- If MCHCP denies your requested amendment/correction and you do **not** submit a written statement of disagreement as discussed above, you may request that MCHCP include a copy of this document with any future disclosures of the information identified in item Nos. 1 and 2 above.
- Make your request in writing, and sign and date the request.
- If you believe we have failed to meet our obligations as explained in MCHCP's Notice of Privacy Practices or MCHCP's legal obligations under state or federal law, you may contact MCHCP's Privacy Officer regarding your complaint. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services within 180 days of the date you know or should know of the act that is the subject of your complaint. Your complaint to the Secretary must be filed in writing, either electronically or on paper.

Revised:12/2013