Blue Cross Community MMAI (Medicare-Medicaid Plan)℠

# Denied Amendment Response

Use this form to respond to our denial of your Amendment Request or to request that your original amendment request and our denial be attached to future disclosures of the Protected Health Information (PHI) that you wanted amended. If you need assistance 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 OR EMAIL TO:**

**c/o Privacy Office**

**Blue Cross Community MMAI**

**P.O. Box 660044**

**Chicago, IL 75266-0044**

**OCA_SSD@bcbstx.com**

**Section A: Please complete the information below for the individual for whom the amendment was denied:**

< _____ >
**<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.)

☐ **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 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 MMAI

| | | | |
|---|---|---|---|
| **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)** | | |

**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**

Blue Cross Community MMAI (Medicare-Medicaid Plan) is provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association. HCSC is a health plan that contracts with both Medicare and Illinois Medicaid to provide benefits of both programs to enrollees. Enrollment in HCSC's plan depends on contract renewal.

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: 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 (TTY 711)

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 1-877-723-7702 (TTY/TDD: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-723-7702 (TTY/TDD: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-723-7702 (TTY/TDD: 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 1-877-723-7702 （TTY/TDD：711

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-877-723-7702 (TTY: TTY/TDD) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-723-7702 (TTY/TDD: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-723-7702 (رقم هاتف الصم والبكم:711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-723-7702 (телетайп: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-877-723-7702 (TTY/TDD: 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-877-723-7702 (TTY/TDD: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-723-7702 (TTY/TDD: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-723-7702 (TTY/TDD: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-723-7702 (TTY/TDD: 711) पर कॉल करें।

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-877-723-7702 (ATS: 711).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-877-723-7702 (TTY/TDD: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-723-7702 (TTY/TDD: 711).