GUARDIAN℠

Amendment of PHI Request

You have the right to request an amendment to your Protected Health Information (PHI), created by Guardian, if you feel it is not correct or incomplete. You have the right to request an amendment for as long as the information is kept by Guardian. You must provide a reason that supports your request.

Guardian reserves the right to deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by Guardian, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the medical information kept by or for Guardian;
- Is not part of the information which you would be permitted to inspect and copy; or
- Is accurate and complete.

Member Information: (Individual whose information will be released)

Name: _____ Date of Birth: _____
(First, Middle, Last) (Month/Day/Year)

Address: _____
City State Zip Code

Telephone Number: _____
(including area code)

Primary Subscriber Name: _____ Member ID: _____

Please provide as much detail as possible regarding the correction or amendment you seek to your protected health information. Be as specific as possible regarding the record type, the location, the date and the problem. For instance, "The request for x-rays related to my dental claim of 3/2/03 was sent to Dr. Jones. It should have been sent to Dr. Watson." or "The address on the Explanation of Benefits dated 3/2/03 was sent to 123 ABC Street. My address at that time was 321 West Haven Street." Such information will assist us in locating the record and information you want corrected. (Please state as precisely as possible how you would like to see the record worded.)

_____

_____

_____

_____

Print Name: _____ Relationship: _____

Signature: _____ Date: _____

Note that no amendment request will be processed unless you or your authorized representative have signed this form.

If you are an authorized representative (other than a parent of a minor child), you will need to provide documentation or an explanation of your authority to act for the member (e.g., Power of Attorney).

Please send this form to:

Guardian Direct Dental
P.O. Box 981587
El Paso, TX 79998-1587