Amendment Request Form

You have the right to request Mutual of Omaha and its affiliates to make corrections or amendments to the protected health information (medical information) we retain on your behalf, if you believe something in that information is in error or needs to be amended. We are not always required to make the corrections or amendments you request, but each request will be carefully reviewed and corrections or amendments made if warranted. You will be notified when your request has been approved or denied. Person whose records should be amended:

Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____ - _____

Home Telephone Number: ( ) _____

Policy/Group Number: _____

If this coverage is provided through an employer, provide the

Subscriber Number: _____

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. If the request is to amend a record that was created by one of your providers, you must include a copy of the provider's amended record. **(Please furnish as much information about the requested correction as possible.)**

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 customer (e.g., Power of Attorney).

Please return completed form and any additional attachments to Mutual of Omaha at:

Mutual of Omaha
Attn: Privacy Office
Mutual of Omaha Plaza
Omaha, NE 68175-1029