



Response to Denied Amendment

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 TO: **Blue Cross and Blue Shield of Oklahoma
P.O. Box 805106
Chicago, IL 60680-4112**

Section A: The individual for whom amendment was denied. Please complete the following:				
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:	
<input type="checkbox"/>	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.)
<hr/> <hr/> <hr/> <hr/>	
<input type="checkbox"/>	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 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 of 18, unless there is proof of legal guardianship.	
Signature	Date: month/day/year

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 and Blue Shield of Oklahoma.				
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)		

Any changes to the format, content or branding of this form are strictly prohibited without review and approval of the HCSC Privacy Office. Please contact the Privacy Office with any change requests.



Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>

BCBSOK provides TDD/TYY services and language assistance for incoming callers for deaf, hard-of-hearing and speech-disabled members. Members can utilize their TeleTYpewriter (TTY) or Telecommunication Device (TDD) to access a teletype operator at 1-800-722-0353.