Clover Health

Request for Correction/Amendment of
Protected Health Information

Use this form to request a correction (amendment) to the information in your health records that are maintained by Clover Health.

Section 1: Member Information	
Name:	
Date of Birth:	Phone Number:
Clover Member ID #:	

Section 2: Correction/Amendment Requested
Date of Entry to be Corrected/Amended:
Description of Protected Health Information (PHI) to Be Corrected/Amended:
Please explain how the entry is incorrect or incomplete. Describe what you believe the entry should state in order to be more accurate or complete.
❑ Check this box if you authorize Clover Health to make reasonable efforts to notify the organization(s) or individual(s) who Clover Health knows may have a copy of the information you seek to have amended and to provide them with the amended information.
PLEASE FILL OUT THE REVERSE SIDE OF THIS FORM.

Section 3: Signature of Member or Authorized Representative

By signing this form, I understand that Clover Health has thirty (30) days to respond to my request for amendment or correction of PHI, starting from the day the request is received. I understand that my request for an amendment may be denied if the PHI or record was not created by Clover Health; the PHI is not part of my designated record set; or the PHI or record is accurate and complete. The designated record set includes certain health records that were used to make decisions about my care.

I understand that this request for an amendment or correction will be made part of my designated record set in response to any authorized requests for my PHI.

❑ Check here if you are signing as an authorized personal representative and provide your information below. Please attach the appropriate documentation (e.g., power of attorney, court order). Please note: the documentation must be validated by our Legal department before an authorized representative signature can be accepted.

Printed Name: _____

Relationship to Member: _____

Signature:	**Date:**

Please mail the completed form to:
Clover Health
P.O. Box 21164
Eagan, MN 55121

Or fax this form to:
Attn: Mailroom
1-866-508-0865