

**Group Insurance Trust of the
California Society of Certified Public Accountants
Request for Amendment**

Please provide the information below. We cannot respond to your request without this information.

Your name: _____

Employee's name: _____ Employee's ID: _____

Use this form to request an amendment of inaccurate or incomplete health information maintained by the Health Plans and used to make decisions about your Health Plan benefits. Be as specific as possible in your description of the incorrect information. **If you have evidence to support your request, please submit it with this form.** Please note that the Health Plans may not amend health information that was originally created by another entity (for example, a medical record sent by your physician). If the incorrect information was created by another entity, you should make your request for amendment directly to that entity.

Describe the inaccurate or incomplete health information:

Describe the proposed amendment to your health information:

Apply this request to the following Health Plans:

- | | |
|--|---|
| <input type="checkbox"/> ProtectPlus Medical Plans (PPO) | <input type="checkbox"/> Managed Health Network (Mental Health) |
| <input type="checkbox"/> CaliforniaCare Medical Plan (HMO) | <input type="checkbox"/> Delta Dental (Dental Plan) |
| <input type="checkbox"/> Vision Service Plan (Vision Plan) | <input type="checkbox"/> Other |

List the names and contact information for any third parties who should be informed of the amendment. By listing these third parties, you agree to allow the Health Plans to share your requested amendment with these third parties if your request is accepted:

_____	_____	_____
_____	_____	_____
_____	_____	_____

The Health Plans will notify you if your request to amend your health information is accepted. Notice of the amendment will be provided to the third parties you have identified above.

For internal use only:	
<input type="checkbox"/> Approved	Notice of extension sent: _____
<input type="checkbox"/> Denied	Date received: _____ Response Date: _____
Include with future disclosures? <input type="checkbox"/> Yes <input type="checkbox"/> No	Amendment Date: _____

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The Health Plans will deny your request for amendment if your health information appears to be accurate and complete. If your request is denied, you will receive a written notice explaining why your amendment was not accepted. You will be permitted to submit a written statement of disagreement if your request is denied, and you may request that the statement be included with future disclosures of the subject health information. If you submit a statement of disagreement, the Health Plans may prepare a rebuttal statement that will also be included with future disclosures. Additional information will be included in your notice of denial.

I hereby request to amend my health information, as described above. I have attached relevant evidence supporting my request for amendment. I understand that the Health Plans will not accept my request if the Health Plans believe that my health information is accurate and complete.

Signature*

Date

**If you are making this request on behalf of another individual, a completed Personal Representative Form must be on file with the Health Plans unless you are the individual's parent or guardian and you are also a participant in a Health Plan.*

Send this completed request form to:

**Banyan Administrators, LLC
Managers for the CalCPA ProtectPlus Programs
1215 Manor Drive, Suite 200
Mechanicsburg, PA 17055
Phone: (877) 480-7923
Fax: (877) 237-4519
CPAProtectPlus@banyan-llc.com**

If you have questions about this form or your right to request to inspect or receive copies of your health information, contact Banyan Administrators, LLC.