Providence
Health Assurance

MEMBER REQUEST FOR AMENDMENT TO RECORDS FORM / FOOMKA CODSIGA XUBINTA EE SAMAYNTA SIXITAANKA DIIWAANNADA

Buuxi foomkan si aad u codsato sixitaan ku saabsan macluumaadkaaga caafimaad ee ay samaysay Providence Health Assurance (PHA). Codsigani waxa uu khuseeyaa oo kaliya diiwaannada oo ay samaysay PHA. PHA ma sixi karto diiwaannada ay sameeyeen hay'ado kale, sida xafiiska ama isbitaalka bixiyahaaga. Codsiyadaas, fadlan si toos ah ula xiriir bixiyahaaga. Fadlan isticmaal kaarkaaga aqoonsiga xubinka (identification, ID) si uu kaaga caawiyo buuxinta macluumaadka Qaybta A.

PART A: MEMBER INFORMATION ***(Provide your name and personal information)*** **/ QAYBTA A: MACLUUMAADKA XUBINKA** ***(Bixi magacaaga iyo macluumaadkaaga shakhsi ahaaneed)***		
Member Last Name / Magaca Ugu Dambeeya ee Xubinka	Member First Name / Magaca Koowaad ee Xubinka	Middle Initial / Magaca Dhexe Xarafka Hore
Member Date of Birth / Taariikhda Dhalashada ee Xubinka	Member Identification Number (see your ID card) / Lambarka Aqoonsiga Xubinta (Ka fiiri kaarkaaga aqoonsiga)	Group Number (see your ID card) / Lambarka Kooxda (fiiri Kaarkaaga aqoonsiga)
Member Home/Street Address / Guriga Xubinka/Cinwaanka Wadada	City, State, and Zip Code / Magaalada, Gobolka, iyo Koodhka Sibka	Preferred Phone Number / Lambarka Taleefanka ee la door biday

PART B: TELL US WHAT INFORMATION YOU WOULD LIKE TO AMEND / QAYBTA B: NOO SHEEG MACLUUMAADKA AAD RABTO INAAD SAXDO

Describe the information you believe is incorrect / Sharax macluumaadka aad aaminsan tahay inuusan sax ahayn: ______________________

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Date(s) of service related to request / Taariikhda(Taariikhaha) adeegga la xiriira codsiga: ______________________

PART C: INDICATE WHERE TO SEND YOUR AMENDED RECORD(S) IF YOUR REQUEST FOR AMENDMENT IS APPROVED / QAYBTA C: SHEEG MEESHA LAGUUGU SOO DIRI DOONO DIIWAANKAAGA(DIIWAANNADAADA) LA SAXAY HADDII CODSIGAAGA SIXITAANKA LA OGGOLAADO

☐ Paper copy to the above mailing address in Part A / U dir nuqul warqad ah cinwaanka boostada ee lagu sheegay Qaybta A

☐ Paper copy to the address below / U dir nuqul warqad ah cinwaanka hoos ku xusan:

Name / Magaca: ______________________

Address / Cinwaanka: ______________________

City, State, Zip / Magaalada, Gobolka, Sibka: ______________________

Phone Number / Lambarka Taleefanka: ______________________

☐ Electronic copy emailed to / U dir nuqul elektaroonig ah iimayl ahaan cinwaanka: ______________________

(Email address) / (Cinwaanka iimaylka)

Information will be sent via secure (encrypted) email unless otherwise specified. Initial if you wish email to be sent unencrypted / Macluumaadka waxaa lagu diri doonaa iimayl ammaan ah (la siray) mooyaane haddii aan si kale loo cayimin. Saxiix haddii aad rabto in iimaylka lagu diro iyada oo aan la sirayn: _________.

Note, some level of risk is associated with sending your health information via unencrypted email or by mail, as your records could be accessed by an unauthorized third party. / Fiiro gaar ah, waxaa jirta heer khatar ah oo lala xiriiriyo marka macluumaadkaaga caafimaadka lagu soo diro iimayl aan la sirayn ama boosto, maadaama diiwaannadaadu ay geli karaan dhinaca saddexaad oo aan la oggolayn.

PART D: MEMBER SIGNATURE AND DATE *(Sign your name and write the date below)* / QAYBTA D: XUBINTA SAXIIXA IYO TAARIIKHDA *(SAXIIX MAGACAAGA OO HOOS KU QOR TAARIIKHDA)*

Member's Signature / Saxiixa Xubinka — *Date / Taariikhda*

Member's Designated Legal Representative/Guardian Signature / Saxiixa Wakiilka Sharciga ee Xubinta Loo Magacaabay/Saxiixa Masuulka — *Date / Taariikhda*

Relationship to Member / Xiriirka uu qofku la leeyahay Xubinka: ☐ *Parent of a Minor / Waalidka Ilmaha yar* ☐ **Legal Guardian / *Masuulka Sharciga ah* ☐ **Power of Attorney / *Dukumentiga Hay'adda Sharciga*

**If this form is signed by someone other than the member, please attach authorizing legal documentation of guardianship or power of attorney. / *Haddii foomkan uu saxeexo qof aan ahayn xubinka, fadlan ku soo lifaaq dukumeenti sharci ah oo ku saabsan mas'uulnimada ama Dukumentiga Hay'adda Sharciga.*

PART E: RETURN THE COMPLETED FORM TO PHA (QAYBTA E: KU SOO CELI FOOMKA LA BUUXIYAY PHA)

Boostada:	Fakiska:	Iimayl:
Providence Health Assurance PO Box 4327 Portland, Oregon 97208-4327	503-574-8608	phpprivacyprogram@providence.org

Haddii aad qabto wax su'aalo ah, fadlan ka wac Providence Medicare Advantage Plans lambarrada 503-574-8000 ama 1-800-603-2340. Isticmaalayaasha TTY waa inay wacaan 711. Waxaan furnahay toddoba maalmood usbuucii, inta u dhaxaysa 8 subaxnimo iyo 8 galabnimo (Waqtiga Baasifigga). Inta u dhaxaysa 1da Abriil iyo 30ka Sebteembar, waxaan xirannahay Sabti iyo Axad kasta.

Maxay ka dhigan tahay xaqayga ah in aan saxno macluumaadka caafimaadkayga?
Adiga ama wakiilkaaga gaarka ah waxaad leedahay xuquuqda inaad codsataan sixitaan ku saabsan macluumaadkaaga caafimaad ee la ilaaliyo oo ay maamusho PHA oo ku jira ururin diiwaanno oo loo qoondeeyay (designated record set, DRS), si waafaqsan Xeerka Wareejinta iyo La-Xisaabtanka Caymiska Caafimaadka ee 1996 (Health Insurance Portability and Accountability Act, HIPAA).

Maxaa ii **muhiim ah inaan fahmo si aan u isticmaalo xuquuqdan?**

- PHA ma sixi karo diiwaannada uu sameeyay qof kale, sida bixiyahaaga, mana beddeli karo macluumaad hore u saxan oo dhammaystiran.
- PHA waxay kaga jawaabi doonaan codsigaaga 60 maalmood gudahooda. Haddii wakhti dheeraad ah loo baahdo, waxaan kugu ogeysiin doonaa qoraal ahaan (illaa 30 maalmood oo dheeraad ah). Haddii codsigaaga la diido, waxaan kuu sharxi doonaa sababta iyo sida aad qoraal ahaan uga jawaabi karto haddii aad khilaafto
- Haddii codsigaaga la ansixiyo, sixitaankaaga waxaa lagu dari doonaa diiwaankaaga.