Zing HEALTH™

Request to Update a Record

REQUEST TO CORRECT, AMEND, OR DELETE A RECORD(S)

PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS.
Mail the signed request to:

Zing Health
225 W. Washington Street, Suite 450
Chicago, IL. 60606
If you need assistance completing the form, please contact Customer Services at 1-866-946-4458 (TTY: 711)

Section 1. Member Information			
Member Last Name:	Member First Name		Member Middle Name:
Date of Birth:	Member ID#:		
Street Address:			
City:	State:	Zip Code:	Phone Number:

After review of my records, I do not feel that original documentation made by _____ accurately reflects medical services provided, inquires made, claims payment or denied on the following date _____. I am requesting a correction or addendum to _____ (identify specific document in question) contained in my medical record.

I request the following correction/amendment be made to my claims and enrollment records.

_____

_____

Please send a copy of the corrected/amended documents to the company or individual listed below:

Company: _____ Name: _____

Address: _____ City: _____ State: _____ Zip: _____

I understand that Zing will amend my information when that information is inaccurate or incomplete. I also understand that Zing Health may or may not supplement my record with an addendum based on this request. If Zing accepts my amendment request, I understand that it will make reasonable efforts to provide the amendment to persons that I have identified as needing it, and to persons that Zing knows might rely on the incorrect information to my detriment.

My request for amendment and any action taken on this request, will become a permanent part of my record, and will be included with any future authorized disclosures.

Zing Health will provide a response to this request within sixty days of its receipt of this request. If the request is denied, Zing will provide me with a written denial, allow me to submit a statement of disagreement for inclusion in the record, and inform me how a complaint to the Secretary of HHS may be filed.

Signature

_____ _____

Member or Representative's Signature Date

_____ _____

Printed Name of Representative (if applicable) Relationship to Member

IF THE PERSON SIGNING THE FORM IS NOT THE MEMBER WHO IS THE SUBJECT OF THE REQUESTED INFORMATION, WRITTEN EVIDENCE OF THE PERSON'S AUTHORITY TO AMEND THE REQUESTED INFORMATION (INCLUDING PROTECTED HEALTH INFORMATION) MUST BE PROVIDED. THAT EVIDENCE MAY BE IN THE FORM OF A WRITTEN AUTHORIZATION FROM THE MEMBER OR A DESIGNATION FROM A COURT OF COMPETENT JURISDICTION.

For Office Use Only

Date Received: _____ Sent to: _____ Title: _____

Date: _____ ☐ Amendment Accepted ☐ Denied: Records are Accurate and Complete

Date Notified: _____ Notified By: _____ Title: _____