AMENDMENT REQUEST FORM

You have the right to request that affiliated entities AultCare Corporation, Aultra Administrative Group (AAG), and AultCare Insurance Company (AIC) which also does business as PrimeTime Health Plan and AultCare HMO, make corrections or amendments to the protected health information we retain on your behalf if you believe something in that information is in error or needs to be amended. We are not always required to make the corrections or amendments you request but each request will be carefully reviewed and corrections or amendments made if warranted. You will be notified when your request has been approved or denied, unless you have either not signed the form or have not provided a reason for the requested correction or change.

Member Name	Date
Group Number	Member ID Number

Please provide as much detail as possible regarding the correction or amendment you seek in your protected health information. Be as specific as possible regarding the record type, the location, the date and the problem. For instance, "The request for pre-authorization of December 5, 2003 references a laboratory test from ABC laboratory for a blood test that I never received" or "Dr. Jones indicated in the records submitted with a claim on December 5, 2003 that I was suffering from weakness in my right leg when in fact the weakness is in my left leg."

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In order to review the requested correction, we must be able to locate the record at issue and the exact entries or reports you want corrected. Please state as precisely as possible how you would like to see the record worded.

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If you are aware of anyone else (such as your physician, pharmacist, hospital, etc.) who also may have a copy of the record you seek to have corrected, please list those persons or organizations here with as much information as you have available regarding names and addresses.

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I hereby authorize notification to the persons/entities I have listed above that may have a copy of the record I seek to have corrected and to provide them with the amended information.

Print Name	Date
Signature*	Date

** Note we will not process any requests that are not signed by you or your representative. If you are the member's representative, please provide documentation or explanation of your authority to act for the member. If you do not have such documentation, please complete the* ***Authorization for Release of Information Form****.*

Please return the completed form to: ATTN: Privacy Coordinator, PO Box 6029, Canton, OH 44706.