



Horizon Blue Cross Blue Shield of New Jersey

## Request for Amendment of Private Information

**Instructions:** To request a change to your records held by Horizon Blue Cross Blue Shield of New Jersey, and its business associates, please complete the information below, sign in the space provided and return to: Horizon BCBSNJ, Centralized Correspondence Unit, P. O. Box 820, Newark, New Jersey 07101-0820.

**Member Information (please print)**

Name: \_\_\_\_\_

Policy Identification #: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone #: \_\_\_\_\_

Date of information/record to be amended: \_\_\_\_/\_\_\_\_/\_\_\_\_

Please list records to be amended and the correction to be made.

**Please be advised that Horizon BCBSNJ does not create or originate medical records. For changes in these records you should consult with your provider.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Please attach documentation that supports your Request for Amendment.**

If an amendment is made, I request that the amended information described be released to the following parties:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
Signature of Member (or Personal Representative)

\_\_\_\_\_  
Date

**Personal representatives who have not previously been registered with Horizon BCBSNJ must submit documentation supporting their authority to make this request.**