



For office use only

Enrollee Request to Amend Record Form

Form with fields: CurrentCare Enrollee Name, Date of Birth, Gender, Enrollee/Patient Address, City, State, Zip Code, Telephone Number, Cell Phone Number, Email.

- 1. Request to Amend CurrentCare Record. I request to amend my CurrentCare Record.
2. Effective Date of Request. This request will become effective when it is received and processed by the Rhode Island Quality Institute (RIQI).
3. Effect of Request. As a result of this request, RIQI will deliver a copy of my request to the provider whose record I request to amend.

Provider Name and Address:

Request to Amend CurrentCare Record

I, _____, request to amend _____
Printed Name of Enrollee
within my CurrentCare Record of the Provider listed above for the period from ___/___/___ to ___/___/___
Month / Day / Year Month / Day / Year

For your protection, we require that the "Enrollee Request to Amend Record" form be authenticated by your physician's office staff if they are a CurrentCare enrollment partner, by a notary public or by a member of the Operations Department at Rhode Island Quality Institute.

I hereby certify that all items on this form have been completed to the best of my knowledge.

Print Name of Patient or Authorized Representative

Date

Signature of Patient or Authorized Representative

Relationship (select one)
Parent
Legal Guardian
Power of Attorney

Print Name of Authenticator or Notary

Date

Please complete and sign this form and mail or hand-deliver the original form to:

CurrentCare
Rhode Island Quality Institute
50 Holden Street, Suite 300
Providence, RI 02908

Facsimiles (fax) and copies will not be accepted.

