LOUISIANA DEPARTMENT OF HEALTH

Denial of Amendment/Correction Request

Insert Client Name and Address	Medicaid ID# or Soc. Sec. #
	Date Filed
	Date Completed

Dear (Client name):

Thank you for submitting your "Request for Amendment/Correction of Health Information form."

Your request has been denied for the following reason(s):

- ❒ The information was not created by the Louisiana Department of Health.
- ❒ The information is not available to you for inspection as permitted by Federal or State law.
- ❒ The information is not part of your record.
- ❒ The information is accurate and complete.
- ❒ Other: _____

If you disagree with all or part of this denial, you may file a written statement of disagreement with:

Office Name:_____

Agency Representative/title: _____

Telephone Number: _____

If you choose not to file a statement of disagreement, you may request that we include your Request for Amendment/Correction of Health Information Form, as well as this denial of your request, with any future disclosures that are related to this amendment.

Sincerely,

Name
Job Title

c: Case File

Sample Form: The Program / Office mailing address must be added.