Excellus
An independent licensee of the Blue Cross Blue Shield Association

CONFIDENTIAL COMMUNICATIONS REQUEST

PLEASE PRINT

PART A: INFORMATION OF MEMBER REQUESTING CONFIDENTIAL ADDRESS			
LAST NAME	FIRST NAME	MI	IDENTIFICATION #(s) *located on ID card(s)*
CURRENT ADDRESS	CITY	STATE/ZIP CODE	RELATIONSHIP TO SUBSCRIBER
ADDITIONAL DEPENDENTS TO WHOM THIS REQUEST APPLIES *(under 18 years of age. 18 or older requires separate form)*			

PART B: REQUEST TYPE (CHOOSE ONLY ONE)

☐ New request for confidential address ☐ Change existing request

☐ Revoke an existing request: Effective _ _ / _ _ / _ _ _

PART C: CONFIDENTIAL ADDRESS *(where you would like mail to be sent)*		
CONFIDENTIAL ADDRESS	CITY	STATE/ZIP CODE
IN CARE OF *(if applicable)*	CONFIDENTIAL PHONE or EMAIL *(where you may be contacted regarding this request)*	

PART D: YOUR RIGHTS (PLEASE READ AND SIGN)

I understand that I have the right to request that I receive communication of my protected health information (PHI) using an alternate, confidential location to avoid endangering me. My request will be accommodated if it is reasonable and I state clearly that failure to use an alternate address could endanger me.

I further understand:

1. **Upon the occurrence of any one of the following:**
   - **a) termination of my health insurance coverage; or**
   - **b) revocation of this Confidential Communication Request; or**
   - **c) a change in your Subscriber/Member Identification number,**

   all communication containing my PHI and/or that of my dependent(s) listed, including information on current or past claims and services, will be mailed to the contract address on file, and available to the subscriber through the web. I understand that if I want my communications to remain confidential after any of the above events, I must contact the Health Plan.
2. Communication to the alternate address will begin within three (3) business days of receipt of this signed document.
3. I can revoke this Confidential Communication Request at any time by writing to the Health Plan at the address listed below, except this revocation would not affect any action taken by the Health Plan in reliance on my request for confidential communication before my written revocation is received.
4. This request applies to communications of my PHI issued by the Health Plan. Information relating to subscriber liability, such as accumulated deductibles and other out of pocket expenses that contribute to family/contract maximums is still available to the subscriber, who is the policyholder.
5. A Confidential Communication Request will revoke any existing authorization on file to release my PHI. I have the right to submit a new authorization using the alternate address.
6. For purposes of ensuring current and accurate information, I will be asked to verify this request by phone, mail or email no less than every 12 months. If present on this form, my email address or telephone number may be used to contact me regarding this request for a confidential address.

IMPORTANT: I attest that failure to communicate my protected health information using the confidential address noted above could endanger me. Further, I understand that the Health Plan will contact me every twelve (12) months to renew my Confidential Communication Request. The Health Plan will not disclose PHI related to my health insurance coverage to another person or organization without my written authorization, unless required or permitted to do so by law.

Signature: _____ Date: _____

If this request is from a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____ Relationship to Individual: _____

Please include documentation related to your authority to act on behalf of the individual, e.g. power of attorney

INCOMPLETE FORMS WILL NOT BE PROCESSED – BE SURE TO RETAIN A COPY FOR YOUR RECORDS

Please complete, sign and return this form to: Excellus Health Plan | P.O. Box 31507 | Rochester, NY 14603

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