

Request for confidential communication



If you believe that the way we currently communicate protected health information could endanger you, use this form to request that communications are delivered to you in a different way.

About confidential communication *(Please read carefully before completing form.)*

We mail communications containing your protected health information, such as an Explanation of Benefits, to the address of the subscriber (the person whose name appears on your ID card). We also rely on telephone information in your membership records when we contact you by telephone.

If you believe the above methods of communication could endanger you, you have the right to request that we use a reasonable alternate method of communication, such as:

- Sending your protected health information to a different address.
- Contacting you at a different phone number.

A request for confidential communication may be denied if you are not in danger, or we can't reasonably accommodate your request.

Within 5 days of receiving your request, we will notify you in writing (at the address you provide in Section C) regarding the approval or denial of confidential communication.

- Because we cannot guarantee that information published online will be seen only by you, the member website will not show any information for you or other members on your account while confidential communication is in place.

A Please identify the MEMBER needing confidential communication

Member name _____ Date of birth _____

Member ID (number on ID card beginning with 1 to 3 letters) _____

B Current address of SUBSCRIBER *(Complete using the enrollment information we have on record).*

Subscriber Address _____

City _____ State _____ ZIP _____

C New address/telephone number for confidential communication

Member Address _____

City _____ State _____ ZIP _____

In care of: *(optional)* _____

Telephone number _____

D Signature (Sign and date the appropriate line)

I attest that I have read the information above and need communication about my protected health information sent by the alternate method provided above because I believe any other method of communication could endanger me.

Note: Complete form by signing in EITHER Section 1 or Section 2.

1 If you are the MEMBER requesting confidential communication

SIGN HERE 

Date _____

2 If you are the member's PERSONAL REPRESENTATIVE

Please provide your name, sign and date. Check the box that best describes your relationship to the member. If it is not already on file, **attach proof of your relationship to the member**. Parents do not need to attach proof.

Representative full name _____

SIGN HERE 

Date _____

Parent of minor (younger than 18) child

Legal guardian: *Attach guardianship documentation (must have a court's stamp and signature).*

Power of attorney: *Attach power of attorney (must include authorization of the release of healthcare information).*

Executor: *Attach letter of appointment of executorship (must have a court's stamp and signature).*

Patient Advocate: *Attach Designation of Patient Advocate form, signed by member.*

Please mail completed form (and documentation if needed) to:

**Customer Individual Rights Unit
BCBSM
600 East Lafayette, MC 1620
Detroit, MI 48226-2998**

or fax to 1-877-348-2210.

