Blue Cross Community Health Plans℠

Confidential Communication Request Form

You have the right to ask Blue Cross Community Health Plans ("the Plan") to use some other address or means of communication for your protected health information (PHI). This can be done to keep from endangering a person. Use this form to ask the Plan to use this address in the future.

This form can also be used end or change a prior approved request. You must complete all fields on this form.

We will accommodate your initial request if all the following criteria are met:

1. Your request is reasonable.
2. You clearly state that not honoring this request could put you in danger.
3. You provide some other reasonable address for the Plan to communicate with you.
4. You provide a reasonable explanation of how payments (if applicable) will be handled if the other address is used.

DO NOT USE THIS FORM TO REQUEST A CHANGE ADDRESS

For help filling out this form, or with a change of address, please call Member Services. The number is listed on the back of your Member ID Card.

When completed and signed please mail to: **Blue Cross Community Health Plans**
c/o Privacy Office
P.O. Box 804836
Chicago, IL 60680-4110

Or email to: **OCA_SSD@bcbstx.com**

Section A: Confidential Communication Request or Change to a Prior Request

Please choose one of the following:

☐ First Request – This form is a first Confidential Communication Request. (Complete entire form.)

☐ Change a prior Request – This form is changing a prior approved Confidential Communication Request. (Complete entire form.)

☐ End a prior request – This form is ending a prior approved Confidential Communication Request. (Complete Section B and go to Section D.)

Enter the date to end the request: _____

Section B: The person asking for another address to be used. Please fill out the following in full:

Name:

_____

Current Address: _____

City: _____State: _____ZIP Code: _____

Phone Number: _____

Email (if available): _____

Date of Birth: _____

Social Security Number: _____

Member ID Number: _____

Group Number: _____

Section C: Please complete the following:

Will you be in danger if the Plan sends your PHI to the address above? If "no", please call Member Services to ask for an address change. The number is on the back of your Member ID Card.

☐ Yes ☐ No

How will you be in danger:

_____

_____

I ask that all my PHI be sent to the address below:

Address:

_____

City: _____State: _____ZIP Code: _____

Phone Number: _____

Email (if available): _____

Please indicate how any payments (if applicable) will be handled using the other address you requested.

_____

_____

_____

_____

If your request is granted, please make note of the following:

1. The request only applies to your current coverage. You must submit a new Confidential Communications Request if your coverage changes. This includes (but is not limited to) changes to Group or Subscriber number, or benefit coverage (i.e., dental coverage is added).
2. The request will expire eighteen (18) months after your benefits coverage has ended.
3. The Plan is only responsible for the PHI that they release to the other address you have chosen in Section C.

Section D: Signature - This form must be signed by the person, parent of minor child or the person's Personal Representative.

I ask that the Plan release my PHI as specified in Section C above. I understand that the Plan is not obligated to agree to my request. I understand I will receive a written determination regarding my request.

I understand that if I am signing on behalf of a minor child, this request will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

_____ _____

Member's signature **Date**

Section E: If Section D is signed by a Personal Representative, please complete the information below:

Chosen legal representative or guardian
If the member has chosen someone to sign this form for them, that person needs to fill out the lines below. Please attach a copy of a Health Care Power of Attorney, a court order or other papers that show that this person may act for the member.

Legal representative or guardian (print full name): _____

Legal relationship to the member_____

Signature: _____ Date: _____

If you have any questions, please call Member Services. We can be reached at **1-877-860-2837**. TTY/TDD users, please dial **711**. We are available 24 hours a day, seven (7) days a week. The call is free.

To ask for supportive aids and services, or materials in other formats and languages for free, please call, 1-877-860-2837 TTY/TDD:711.

Blue Cross and Blue Shield of Illinois complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Blue Cross and Blue Shield of Illinois does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Illinois:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Civil Rights Coordinator.

If you believe that Blue Cross and Blue Shield of Illinois has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35th floor, Chicago, Illinois 60601, 1-855-664-7270, TTY/TDD: 1-855-661-6965, Fax: 1-855-661-6960. You can file a grievance by phone, mail, or fax. If you need help filing a grievance, Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ENGLISH: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call **1-877-860-2837 (TTY/TDD: 711)**.

ESPAÑOL (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-860-2837 (TTY/TDD: 711)**.

POLSKI (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-877-860-2837 (TTY/TDD: 711).**

繁體中文 (Chinese): 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-860-2837 (TTY/TDD: 711).**

한국어(Korean): 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-860-2837 (TTY/TDD: 711)**번으로 전화해 주십시오.

TAGALOG (Tagalog – Filipino): PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-860-2837 (TTY/TDD: 711)**.

العربية (Arabic):
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-860-2837 (رقم هاتف الصم والبكم: 711).**

РУССКИЙ (Russian): ВНИМАНИЕ: Если Вы говорите на русском языке, то Вам доступны бесплатные услуги перевода. Звоните **1-877-860-2837 (Телетайп: 711)**.

ગુજરાતી (Gujarati): સુચના: જો તમે ગુજરાતી બોલતા હો, તો મન:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો **1-877-860-2837 (TTY/TDD: 711)**.

اردو (Urdu):
یاد رکھیں: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔
1-877-860-2837 (TTY: 711) پر کال کریں۔

Tiếng Việt (Vietnamese): CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-860-2837 (TTY/TDD: 711)**.

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero **1-877-860-2837 (TTY/TDD: 711)**.

हिन्दी (Hindi): ध्यान दें: यदि आप हिन्दी बोलते हैं, तो आपके लिए भाषा सहायता सेवाएं निःशुल्क उपलब्ध हैं। **1-877-860-2837 (TTY/TDD: 711)** पर कॉल करें।

FRENCH (French): ATTENTION: Si vous parlez français, des services d'assistance linguistique vous sont proposés gratuitement. Appelez le **1-877-860-2837 (TTY/TDD : 711)**.

ΕΛΛΗΝΙΚΑ (Greek): ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε **1-877-860-2837 (TTY/TDD: 711)**.

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-860-2837 (TTY/TDD: 711)**.