Blue Cross Community MMAI (Medicare-Medicaid Plan)℠

Confidential Communication Request Form

Do you believe that you would be in danger if your Protected Health Information (PHI) were sent to your current address?

☐ ***Yes*** ☐ ***No***

If you answered yes, fill out and return this form. This form asks Blue Cross Community MMAI or our Business Associates to deliver PHI to you at a different address or by other means.

You may also fill out this form to end or change an existing Confidential Communication Request.

You must fill out all the fields on this form.

Your initial request will be approved if all of the following are met:

1. Your request is reasonable;

2. You clearly state that our failure to honor this request could put you in danger;

3. You provide an address or another reasonable way for us to communicate with you, and;

4. You provide a reasonable explanation of how payments (if this applies) will be handled if the other location is used.

DO NOT USE THIS FORM TO REQUEST AN ADDRESS CHANGE

If you need help filling out this form, or with a change of address, please call Member Services at **1-866-689-1523** (TTY: **711**).

WHEN COMPLETED AND SIGNED, PLEASE RETURN TO:

C/O PRIVACY OFFICE

Blue Cross Community MMAI

P.O. Box 660044

Dallas, TX 75266-0044

OCA_SSD@bcbstx.com

Section A: Confidential Communication Request or Modification/ Termination of Existing Confidential Communication Request

Please choose one of the following:

☐ Initial Request – This is your first Confidential Communication Request. (Complete entire form.)

☐ Modify a Previous Request – This form is changing (i.e., adding an alternative address) a prior approved Confidential Communication Request. (Complete entire form.)

Section B: Member Information

Name: <_____>

Address: <_____>

City: <_____> State: <_____> ZIP Code: <_____>

Phone Number: <_____>

Email Address (if available): <_____>

Date of Birth: <_____>

Social Security Number: <_____>

Member ID Number: <_____>

Section C: Please complete the section below for your request:

Alternative Location Address: <_____ >

City: <_____> State: <_____> ZIP Code: <_____>

Phone Number: <_____>

Email Address (if available): <_____>

Payment information will be sent to alternate address until further notice.

<_____

_____

_____>

If your Confidential Communications Request is approved:

1. The request only applies to your current coverage. If any of the information about your coverage changes, you must submit a new Confidential Communication Request. Changes may include a new Group or Subscriber number or benefit coverage changes.

2. The request will expire eighteen (18) months after coverage.

3. Blue Cross Community MMAI and its Business Associates are only responsible for the PHI that they release to the alternative address you have designated in Section C.

Section D: Signature. This document must be signed by the Member, parent of minor child, or the Member's authorized representative.

I request that Blue Cross Community MMAI release my PHI using the means in Section C above. I understand that Blue Cross Community MMAI does not have to agree to my request. I understand I will receive a written decision 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.

<Signature>	**<Date>**

Section E: If Section D is signed by an authorized representative, please complete the information below:

Chosen legal representative or guardian:
If the member has chosen someone to sign this form for him or her, 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: <_____>

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call Member Services at 1-877-723-7702 (TTY: 711). We are available seven (7) days a week. Our call center is open Monday-Friday 8:00 a.m. – 8:00 p.m. Central time. On weekends and Federal holidays, voice messaging is available. If you leave a voice message, a Member Services representative will return your call no later than the next business day. The call is free.

ATENCIÓN: Si habla español, los servicios de asistencia lingüística están a su disposición sin costo alguno para usted. Llame al 1-877-723-7702 (TTY: 7-1-1). Estamos a su disposición los siete (7) días de la semana. Nuestra central telefónica está abierta de lunes a viernes de 8:00 a. m. a 8:00 p. m., hora del centro. Para los fines de semana y días feriados federales, está disponible el servicio de mensajes de voz. Si deja un mensaje de voz, un representante de Atención al Asegurado le devolverá la llamada antes del próximo día laborable. La llamada es gratuita.

Blue Cross Community MMAI (Medicare-Medicaid Plan) is provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of the Blue Cross and Blue Shield Association. HCSC is a health plan that contracts with both Medicare and Illinois Medicaid to provide benefits of both programs to enrollees. Enrollment in HCSC’s plan depends on contract renewal.

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: 1-855-661-6965, Fax: 1-855-661-6960, Civilrightscoordinator@hcsc.net. You can file a grievance in person or by mail, fax, or email. 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.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you.
Call 1-877-723-7702 (TTY/TDD: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-723-7702 (TTY/TDD: 711).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-877-723-7702 (TTY/TDD: 711).

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 1-877-723-7702
（TTY/TDD：711

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-877-723-7702 (TTY: TTY/TDD) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-723-7702 (TTY/TDD: 711).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-877-723-7702
(رقم هاتف الصم والبكم:711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните 1-877-723-7702 (телетайп: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો

1-877-723-7702 (TTY/TDD: 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں
1-877-723-7702 (TTY/TDD: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.
Gọi số 1-877-723-7702 (TTY/TDD: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-877-723-7702 (TTY/TDD: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
1-877-723-7702 (TTY/TDD: 711) पर कॉल करें।

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.
Appelez le 1-877-723-7702 (ATS: 711).

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-877-723-7702 (TTY/TDD: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-877-723-7702 (TTY/TDD: 711).