



Confidential Communication Request Form

You have the right to request that Blue Cross and Blue Shield of Oklahoma communicate with you by alternative means or at an alternative location if the disclosure of your Protected Health Information could endanger you. Please use this form to initiate a request of this nature.

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

1. Your request is reasonable;
2. You clearly state that failure to honor your request could endanger you;
3. You provide reasonable alternative means or location for communicating with you, and;
4. You provide a satisfactory explanation of how your payments (if applicable) will be handled if the alternative location is used.

PLEASE NOTE: DO NOT USE THIS FORM TO SIMPLY CHANGE YOUR ADDRESS.
If you need assistance in completing this form, or with a change of address, please call the Customer Service number listed on the back of your Member Identification Card.

You may also use this form to terminate or modify a previously granted request for confidential communications.

**WHEN COMPLETED AND SIGNED PLEASE MAIL TO: Blue Cross and Blue Shield of Oklahoma
 P.O. Box 805106
 Chicago, IL 60680-4112**

Section A: Confidential Communication Request or Modification/Termination of Previous Request	
Please choose one of the following:	
<input type="checkbox"/> Initial Request – This form is an initial Confidential Communication Request. (Complete entire form.)	
<input type="checkbox"/> Modify a previous Request – This form is modifying (i.e., changing the alternative address) a previously approved Confidential Communication Request. (Complete entire form.)	
<input type="checkbox"/> Terminate a previous Request – This form is terminating a previously approved Confidential Communication Request. (Complete Section B and proceed to Section D.)	Enter date to terminate previous request Date: month/day/year

Section B: The individual for whom communication at an alternative location is being requested. Please complete the following:			
Name _____	Group # _____	Identification\Subscriber # _____	
Social Security Number _____	Date of Birth _____		
Address _____	City _____	State _____	ZIP _____
Area Code & Telephone Number _____	E-mail address (if available) _____		

Section C: Please complete the following about the confidential communication request:
Will the failure to communicate your PHI through an alternative location endanger you? If you select "no", please call the customer service number on the back of your identification card to request an address change. <input type="checkbox"/> Yes <input type="checkbox"/> No



Section C (cont): Please complete the following about the confidential communication request:

I request that all of my PHI be communicated at the alternative location listed below:

Alternative Location: Street Address: _____

 City: _____ State: _____ Zip: _____
 Phone number: _____

Please indicate how any payments (if applicable) will be handled using the alternative location that you request.

If this request is granted, please note the following:

1. The request will only apply to your current Group and Subscriber Numbers and benefits coverage. If your Group or Subscriber Numbers change, or your benefits coverage changes (i.e., dental coverage is added), you must submit a new Confidential Communications Request for the new group/subscriber number or benefit coverage.
2. This request will expire eighteen (18) months after your benefits coverage has terminated.
3. Blue Cross and Blue Shield of Oklahoma 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 individual, parent of minor child or the individual's Personal Representative.

I request that Blue Cross and Blue Shield of Oklahoma release my PHI as specified in Section C above. I understand that Blue Cross and Blue Shield of Oklahoma is under no obligation 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.

Signature **Date: month/day/year**

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

If you are signing as a Power of Attorney, Legal Guardian, Executor, or Administrator attach a copy of the Legal documents. You do **NOT** have to attach copies of these documents if they are already on file with Blue Cross and Blue Shield of Oklahoma.

Personal Representative's Name **Relationship to Individual**

Personal Representative's Address **City** **State** **ZIP**

Personal Representative's Area Code & Telephone Number **Personal Representative's E-mail address (if available)**