



Confidential Communication Request Form

Use this form to either request Blue Cross and Blue Shield of Oklahoma or one of its Business Associates to communicate with you at an alternative location or by alternative means or to terminate or modify a previously granted Confidential Communication request. You must complete all the fields on this form.

We will accommodate your initial request if all of the following criteria 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 a location or another reasonable alternative for us to communicate with you, and;
4. You provide a reasonable explanation of how payments (if applicable) will be handled if the alternative location is used.

DO NOT USE THIS FORM TO REQUEST A CHANGE 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.

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

OR EMAIL TO: **OCA_SSD@bcbstx.com**

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

1. The request only applies to your current coverage. If any of the information about your coverage changes including Group or Subscriber number, benefit coverage changes (i.e., dental coverage is added), you must submit a new Confidential Communications Request.
2. The 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)

Any changes to the format, content or branding of this form are strictly prohibited without review and approval of the HCSC Privacy Office. Please contact the Privacy Office with any change requests.



Health care coverage is important for everyone.

We provide free communication aids and services for anyone with a disability or who needs language assistance.
We do not discriminate on the basis of race, color, national origin, sex, gender identity, age or disability.

To receive language or communication assistance free of charge, please call us at 855-710-6984.

If you believe we have failed to provide a service, or think we have discriminated in another way, contact us to file a grievance.

Office of Civil Rights Coordinator
300 E. Randolph St.
35th Floor
Chicago, Illinois 60601

Phone: 855-664-7270 (voicemail)
TTY/TDD: 855-661-6965
Fax: 855-661-6960
Email: CivilRightsCoordinator@hcsc.net

You may file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Dept. of Health & Human Services
200 Independence Avenue SW
Room 509F, HHH Building 1019
Washington, DC 20201

Phone: 800-368-1019
TTY/TDD: 800-537-7697
Complaint Portal: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>
Complaint Forms: <http://www.hhs.gov/ocr/office/file/index.html>

BCBSOK provides TDD/TYY services and language assistance for incoming callers for deaf, hard-of-hearing and speech-disabled members. Members can utilize their TeleTYpewriter (TTY) or Telecommunication Device (TDD) to access a teletype operator at 1-800-722-0353.