BlueCross BlueShield of Illinois

Confidential Communication Request Form

Use this form to either request Blue Cross and Blue Shield of Illinois 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 your Member Identification Card.

WHEN COMPLETED AND SIGNED PLEASE MAIL TO:

Blue Cross and Blue Shield of Illinois
P.O. Box 660044
Dallas, TX 75266-0044
OCA_SSD@bcbstx.com

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

Please choose one of the following:

☐ **Initial Request –** This form is an initial Confidential Communication Request. (Complete entire form.)

☐ **Modify a previous Request –** This form is modifying (i.e., changing the alternative address) a previously approved Confidential Communication Request. (Complete entire form.)

☐ **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. ☐ **Yes** ☐ **No**

BlueCross BlueShield of Illinois

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 Illinois 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 Illinois release my PHI as specified in Section C above. I understand that Blue Cross and Blue Shield of Illinois 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 Illinois.

_____ _____

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.