



CONFIDENTIAL COMMUNICATION REQUEST

Purpose: This form is used for an individual's request that we use alternative means or an alternative location when communicating about protected health information.

The Member's Information: Insert information about the individual requesting confidential communication.

Member Name: \_\_\_\_\_ Member ID Number: \_\_\_\_\_
Member Address: \_\_\_\_\_ Member Date of Birth: \_\_\_\_\_
Member Social Security No.: \_\_\_\_\_
Member Phone Number: \_\_\_\_\_ Member e-Mail: \_\_\_\_\_

SECTION B: To the individual—please read the following and complete the information requested.

Your Rights: You have the right to request that we communicate about all or part of your protected health information by alternative means or to an alternative location to avoid endangering you.

Please explain why you request confidential communication about your protected health information by alternative means or to an alternative location:

The following information generated by BlueCross BlueShield of Tennessee is subject to confidential communication:

- Explanation of Benefits (EOB)
• Written Correspondence (i.e. letters)
• Telephone Inquiries

Collection of premiums or other payments will not be altered by this request. The subscriber will be aware of any applicable charges (i.e. total dollar amounts only) that are applied to family deductibles, out-of-pocket amounts or lifetime maximum benefit calculations.

INDIVIDUAL'S SIGNATURE.

I attest that failure to communicate about my protected health information by the alternative means or to the alternative location I request could endanger me.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this request is by a personal representative on behalf of the individual, complete the following:
Personal Representative's Name: \_\_\_\_\_
Relationship to Individual: \_\_\_\_\_

YOU ARE ENTITLED TO A COPY OF THIS REQUEST.

Please return completed form to:

BlueCross BlueShield of Tennessee
Privacy Office
1 Cameron Hill Circle
Chattanooga TN 37402