BlueCross BlueShield of Texas

Confidential Communication Request Form

Use this form to either request Blue Cross and Blue Shield of Texas, or one of its Business Associates, to communicate with you at a different location or by alternative means or to terminate or change a previously granted Confidential Communication request.

This Form is to be used by an individual to exercise his/her right to request that Blue Cross and Blue Shield of Texas, or one of its Business Associates, use a different address when communicating about protected health information to avoid endangering the individual. 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 place or another reasonable place for us to communicate with you, and;

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

DO NOT USE THIS FORM TO REQUEST A CHANGE ADDRESS

If you need help 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 OR EMAIL TO:

Blue Cross and Blue Shield of Texas
P.O. Box 805106
Chicago, IL 60680-4112

OCA_SSD@bcbstx.com

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

☐ ***Yes*** ☐ ***No***

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.)

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Section B: The individual for whom communication at a different location is being requested. Please complete the following:

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 following about the confidential communication request:

Alternate Location

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____

Email address (if available): _____

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

Section E: If Section D is signed by a Personal 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: _____

To get auxiliary aids and services, or to get written or oral interpretation to understand the information given to you, including materials in alternative formats such as large print, braille or other languages, please call BCBSTX Customer Service on the back of your Member ID card.

Blue Cross and Blue Shield of Texas 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 Texas does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Blue Cross and Blue Shield of Texas:

- 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 Texas 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/TDD: 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 1-855-710-6984 (TTY: 711).

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-710-6984 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-710-6984 (TTY: 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 1-855-710-6984 (TTY: 711)。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-710-6984 (TTY: 711) 번으로 전화해 주십시오.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-710-6984 (رقم هاتف الصم والبكم: 711).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-855-710-6984 (TTY: 711).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-710-6984 (TTY: 711).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-710-6984 (ATS: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-855-710-6984 (TTY: 711) पर कॉल करें।

هجوت: اب .دشاب یم مهارف امش یارب ناگیار تروص هب ینابز تلایهست ،دینک یم وگتفگ یسراف نابز هب رگا 1-855-710-6984 (TTY: 711) دیریگب سامت.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-710-6984 (TTY: 711).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-855-710-6984 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-710-6984 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-710-6984（TTY: 711）まで、お電話にてご連絡ください。

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-710-6984 (TTY: 711).