



Blue Cross Blue Shield of Michigan
 Blue Care Network of Michigan
 BCN Service Company
 BlueCaid of Michigan

CONFIDENTIAL COMMUNICATION REQUEST

Use this form to request that you receive communications of protected health information (PHI) by alternative means, or at an alternate location.

Please complete the following:

NAME		DAYTIME PHONE NUMBER	
ADDRESS			
CITY	STATE	ZIP	CONTRACT NUMBER

Please read and complete the following:

At BCBSM, we mail communications containing your PHI, such as an Explanation of Benefits, to the subscriber (the person whose name appears on your ID card). At BCN, communications are addressed to your address as listed in our membership records. We also rely upon telephone information in your membership records when we contact you by telephone. If you believe this method of communication could endanger you, you have the right to request that we:

- Use a reasonable alternate means for communicating your PHI
- Send your PHI to an alternate address
- Contact you at an alternate phone number

Please note that we are not able to accommodate requests for communications to alternate addresses made solely for reasons of convenience.

I request that BCBSM/BCN communicate with me about my PHI by alternate means, to send such communications to an alternate address, and/or to contact me at an alternate phone number. (Please provide full information regarding the alternate means, address, phone number, etc. that you want us to use.)

Does this request include information about services received at a BCN Health Center? Yes No

Please sign and date:

I have read the above statement and attest that I require communication about my PHI by the following alternate means or to the alternate address indicated above.

Signature	Date

If you are not the member, please sign and write today's date below, then check the box that describes your relationship to the member. If you are not the parent of the member, please attach proof of your relationship to the member.

Please Print Name of Personal Representative: _____

Signature of Personal Representative	Date

Parent Legal Guardian Power of Attorney Executor Other _____

**Please return this form to: Customer Individual Rights Unit, MC 2004
 BCBSM/BCN - P.O. Box 2459
 Detroit, MI 48231-2459**