REQUEST FOR ALTERNATE MEANS OF CONFIDENTIAL COMMUNICATIONS

Use this form to request that you receive communications of protected health information (PHI) by alternative means, or at an alternate location. By granting confidential communications, BCBSM/BCN will not disclose your PHI to any other individuals who may contact us on your behalf unless written authorization has been submitted.

Please complete the following:

NAME			DAYTIME PHONE NUMBER
ADDRESS			
CITY	STATE	ZIP CODE	ENROLLEE ID

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.)

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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 [illegible], please [illegible] sign and date below. [illegible]heck the box that describes your relationship to the [illegible]. [illegible]lease attach proof of your relationship to the [illegible]

Please Print Name of Personal Representative: ______________________________

______________________________ ____________________

Signature of Personal Representative Date

☐ Parent on Minor Child ☐ 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