BlueCross BlueShield
of Illinois

Confidential Communication Request Form

Use this form to request that Blue Cross and Blue Shield of Illinois use an alternative location when communicating with you about your Protected Health Information (PHI). You have the right to request that we communicate with you about your PHI at an alternative location. **If you need assistance in completing this form, please call the Customer Service number listed on the back of your Member Identification Card.**

We will accommodate your request if all of the following criteria are met:

1. Your request is reasonable;
2. You clearly state that failure to honor your request could endanger you;
3. You provide reasonable alternative means or location for communicating with you, and;
4. You provide a satisfactory explanation how any payments (if applicable) will be handled using the alternative location that you request.

You may also use this form to terminate or modify a previously granted request for confidential communications.

WHEN COMPLETED AND SIGNED PLEASE MAIL TO: **Blue Cross and Blue Shield of Illinois**
P.O. Box 805106
Chicago, IL 60680-4112

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? ☐ **Yes** ☐ **No**

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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 this request is granted, please note the following:

1. **The request will only apply to your current Group and Subscriber Numbers and benefits coverage. If your Group or Subscriber Numbers change, or your benefits coverage changes (i.e., dental coverage is added), you must submit a new Confidential Communications Request for the new group/subscriber number or benefit coverage.**
2. **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)**

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