BLUE Benefit
ADMINISTRATORS OF MASSACHUSETTS
An independent licensee of the Blue Cross and Blue Shield Association.

CONFIDENTIAL COMMUNICATION REQUEST

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

SECTION A: Individual requesting confidential communication.

Name:

Address:

Telephone: E-mail:

Identification Number: Social Security Number:

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

You have the right to request that we communicate all or part of your protected health information by alternative means or to an alternative location to avoid endangering you. We will accommodate your request if (a) it is reasonable, (b) you state clearly that failure to communicate your protected health information by the alternative means or to the alternative location could endanger you, (c) you provide reasonable alternative means or location for communicating with you, and (d) a satisfactory explanation how any applicable premium or other payments will be handled under the alternative means or location you request. We will not investigate the validity of your claim that failure to communicate with you by the alternative means or location could endanger you. To exercise this right, please complete this Section.

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

Please describe the protected heath information you want to make subject to confidential communication:

Please explain how any applicable premium or other payments will be handled:

☐ I request that you communicate with me about my protected health information by the following alternative means. Please provide full information on the alternative means you want us to use:

☐ I request that you communicate with me about my protected health information at the following alternative location. Please provide full information on the alternative location:

INDIVIDUAL'S SIGNATURE

I attest that failure to communicate 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 AUTHORIZATION AFTER YOU SIGN IT

Return form to:

BLUE Benefit Administrators of Massachusetts
Attention: HIPAA/Privacy Officer
PO Box 55917, Boston, MA 02205-5917
FAX# 877-596-2583