Request for Confidential Communication

About Confidential Communication

Fill out this form *only* if you believe you're in danger or you could possibly be in danger. If you have any questions about how the confidential communication process works, call Customer Care at (833) 865-0141.

We mail communications containing your protected health information (PHI), such as an Explanation of Benefits, to the address of the subscriber/employee/policyholder (the person whose name appears on your ID card). We also rely on telephone information in your enrollment records when we contact you by telephone. If you believe these methods of communication could endanger you, you have the right to request that we use a reasonable alternate method of communication, such as:

- Sending your protected health information to a different address
- Contacting you at a different phone number

Within this form, the terms "you" and "your" refer to the member or, if applicable, their parent/guardian or authorized representative. The terms "we", "our", and "us" refer to Healthcare Management Administrators (HMA), your third-party Health Plan administrator. The term "spouse" may also encompass domestic partners, depending on the laws in your area.

Within three business days of receiving your request for confidential communication, we'll send notification to you in writing regarding the outcome of your request. If your request is approved, notification will be sent, in writing, to the new mailing address you provide below. Please note the following:

- If your request for confidential communication is approved, the member portal won't show information for you or *any* members on your account. This is because we can't guarantee that information published online will be seen only by you.
- If you aren't in danger or if we can't reasonably accommodate your request for confidential communication, your request may be denied.
- If we have questions about your request, we may reach out to you before we're able to make a determination.

If requesting confidential communication for multiple members, fill out a separate form for each member.

Submission Information

You may provide the information in this form to us using one of the methods below (pick any option that works for you)**:**

Electronic Submission Options

✓ **Option 1: Fill out Online**:

1. Go to : mi.accesshma.com and then go to **Download Member Forms**
2. Click on the DocuSign option under **Request for Confidential Communication Form**
3. Fill out and submit the form in DocuSign

✓ **Option 2: Fill out a PDF Form** (not recommended on mobile devices and in Internet browsers):

1. Go to mi.accesshma.com and then go to **Download Member Forms**
2. Click on the PDF option under **Request for Confidential Communication Form**
3. Fill out the form in compatible PDF software like Adobe Reader or Acrobat
4. Email your completed form to: PrivacyOffice@accesstpa.com (no printing or mailing required)

Paper Submission

✓ **Mail** the completed form to:
HMA
Attn: Privacy Office
PO Box 52730
Bellevue, WA 98015-2730

This document contains sensitive information that is confidential to the addressee and should not be copied, distributed, or reproduced in whole or in part.

HMA

Request for Confidential Communication

Applicability Check

1. Do you believe you would be in danger if we send communications about your health information to the address / phone number we have on file for the subscriber*?
   - ○ **Yes**, I believe this would put me in danger
   - ○ **No,** I don't believe this would put me in danger

   ** The term "subscriber" is also known as "policyholder". If you're the subscriber, please contact us. It's likely you **don't** need to fill out this form.*

2. Are you the subscriber/policyholder for this policy or are you a spouse/dependent on this policy?
   - ○ **Subscriber:** I'm the person who holds this policy through my employer

     ***Note:** The need for confidential communication generally applies only to spouses and dependents. If you're the subscriber on this policy, the need for confidential communication likely **doesn't** apply to you. Please contact us.*
   - ○ **Spouse/Dependent:** I'm *not* the policyholder; I have this policy through my spouse or parent/guardian

Subscriber Information

Provide the subscriber's information. This is the person whose name is listed on the insurance ID card as the "employee".

First Name _____ **Last Name** _____

Mailing Address _____

City _____ **State** _____ **ZIP** _____

Requester/Your Information

List to whom this request applies. If requesting for multiple members, fill out a separate form for each member.

First Name _____ **Last Name** _____

Date of Birth _____ **Member ID Number**[?] _____

Group ID Number[?] _____ **Group Name** _____

[?] *This information can be located on your insurance ID card. "Member ID" is also called "Employee ID".*

New Contact Information to Use for Confidential Communication

Provide the *new* contact information to use for the member listed above.

Mailing Address _____

City _____ **State** _____ **ZIP** _____

Care of (optional) _____

Phone Number _____ **Email (optional)** _____

Relationship to Requester

Indicate your relationship to the member requesting confidential communication:

- ○ **Self** - I am completing this form on my own behalf (most common option)
- ○ **Parent of minor** (younger than 18) child
- ○ **Legal Guardian**: Attach guardianship documentation (must have a court's stamp and signature)
- ○ **Power of Attorney**: Attach power of attorney (must include authorization of the release of healthcare information)
- ○ **Executor**: Attach letter of appointment of executorship (must have a court's stamp and signature)
- ○ **Authorized Representative**: Attach Authorized Representative form, signed by member

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Notes/Comments

List any additional information you think we should know. If you're unable to fit everything within this box, you may attach additional pages as necessary. **Note**: This field shouldn't serve as a substitute for filling out the rest of the fields in this form.

Attachments

Include all relevant material, if applicable.

Signature

_____

Printed Name (First and Last)

_____ _____

Signature **Date**

By signing this Form you attest that 1) You are the member referenced herein, their parent/guardian, or are otherwise legally authorized to represent them; 2) You have read the information above and need communication about your protected health information sent by the alternate method provided above because you believe any other method of communication could endanger you; 3) The information listed herein is correct to the best of your knowledge.

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