

# Request for Confidential Communication of Protected Health Information

You have the right to request that your protected health information maintained by Health Advantage be communicated to you in a confidential or alternate manner if you are in danger of personal harm if the information is not kept confidential. The request must be in writing, and you may use this form to make sure all required information is included. You are not required to use this form but must include all information below for the request to be processed. You may make your request by phone in an emergency situation. A phone request must be followed with a written request to be effective.

The request must be in writing and must contain the following information:

<b>Full name</b>		<b>Date of birth</b>	<b>Member ID number</b>
<b>Current address</b>	<b>City</b>	<b>State</b>	<b>ZIP</b>
<b>New address you wish to use</b>	<b>City</b>	<b>State</b>	<b>ZIP</b>
<b>Phone number where we can contact you</b>	<b>Reason you are requesting confidential communications</b>		

The request must be mailed or faxed to the Arkansas Blue Cross and Blue Shield Privacy Office at:  
 PO Box 3216  
 Little Rock, AR 72203  
**Fax number:** 501-378-2975

Please note that claims or correspondence processed prior to the change of address effective date will be sent to the old address. Family deductibles amounts paid, and out-of-pocket maximum accumulators will continue to be reflected on Explanation of Benefits (EOB) received by the subscriber.

### Effective Date

You will receive a confirmation notice or request for more information at the new address you have indicated. The change will be in place after you receive the acknowledgment from us. Until that time, you must assume that all correspondence will go to the original address.

### Cancellation of Address Change

To cancel the change of address, a written request must be received and processed by the Privacy office. When a confidential communications order is canceled, all information will once again be available to the policyholder.

<b>Signature</b>	<b>Date</b> (Month / Day / Year)  / /
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