REQUEST FOR CONFIDENTIAL COMMUNICATIONS

An Independent Licensee of the Blue Cross and Blue Shield Association

ALL SECTIONS MUST BE COMPLETED UNLESS OTHERWISE SPECIFIED

PART A: INFORMATION of MEMBER REQUESTING CONFIDENTIAL COMMUNICATIONS

Last Name	First Name		MI
Address	City	State	ZIP Code
Email (if available)	Home Phone #	Cell Phone # (if available)	
HMSA Subscriber Number(s) (From your HMSA membership card; confidential communications will only apply to account(s) listed below.)		Birth Date (mm/dd/yyyy)	

PART B: REQUEST TYPE (Choose only ONE request per form)

☐ **New Request** – I want to begin confidential communications.

☐ **Update Existing Request** – I want to make a change to my current confidential communications (e.g., change my alternate mailing address or contact numbers).

☐ **Revoke Request** – I no longer need confidential communications; please cancel beginning on the following date: **(mm/dd/yyyy):** _____

PART C: ATTESTATION OF ENDANGERMENT (REQUIRED)

Federal privacy laws give you the right to request confidential communications to avoid endangerment. Any misrepresentation of your endangerment could subject you to fines or other penalties under federal law.

BY INITIALING THIS SECTION, I ATTEST THAT FAILURE TO COMMUNICATE MY PROTECTED HEALTH INFORMATION THROUGH ALTERNATIVE MEANS OR TO AN ALTERNATE LOCATION COULD ENDANGER ME. (Initial here)_____

PART D: ALTERNATE COMMUNICATION INFORMATION

HMSA will handle your confidential communications by sending your mail to an alternate address other than the subscriber's address or by allowing you to pickup your mail at an HMSA Center or office. Please choose only ONE option below.

☐ **Pickup all my communications at an HMSA Center or office** (Check one)

☐ Honolulu ☐ Pearl City ☐ Hilo ☐ Kona ☐ Maui ☐ Kauai

☐ **Mail all my communications to my alternate address below:**

Alternate Mailing Address (other than subscriber's address)	City	State	ZIP Code

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PART E: YOUR INDIVIDUAL RIGHTS

I understand that (**please read**):
HMSA will accommodate reasonable requests to receive communications of protected health information by alternative means or at alternative locations if I state clearly that failure to do so could endanger me. I'm not required to explain the basis for my request as a condition of confidential communications. I'm entitled to receive a copy of this signed form.

I further understand that:

- Correspondence addressed to me will be subject to confidential communications.
- Requests will be accommodated unless the alternative means for communication isn't reasonable or isn't valid.
- An incomplete form won't be processed and will be returned to me for completion.
- Confidential communications will supersede and take priority over any existing Authorized Representative requests.
- Until my account information is updated, my correspondence will continue to be mailed to the subscriber's address. Also, any checks I receive from HMSA could be sent to me but made payable to the subscriber unless I make other payment arrangements with HMSA. My services may be indirectly reflected on reports sent to the subscriber, such as communications about plan deductibles.
- If the subscriber or I change health plans, subscriber IDs, or employers, I'll need to resubmit this request.
- This request will **expire one year** after it becomes effective. I may renew this request if my plan is active.
- I must inform HMSA of changes to my alternate contact information. If my alternate contact information becomes invalid, HMSA will make reasonable attempts to contact me. If HMSA can't reach me, this request will expire.
- This request will **expire 18 months** after termination of my health plan benefits coverage.
- If I cancel my request for confidential communications or the request expires, the restriction will be removed for all my HMSA correspondence, including information previously protected.
- If I have questions about this form, I may contact HMSA at (808) 948-6111 on Oahu.

PART F: YOUR SIGNATURE

I, (print member's name) _____, have had full opportunity to read and understand the contents of this form and agree to all conditions described herein.

Signature*: _____ **Date:** _____

If the member requiring confidential communications is less than 18 years old, a parent or guardian with appropriate authority must sign below. Exceptions may be made for certain minors in compliance with Hawaii state law. If a legal representative, such as an agent with Medical Power of Attorney, is making this request, verification of your legal authority (e.g., copy of Medical Power of Attorney documentation) is required.* ***COMPLETION OF THE FOLLOWING SECTION IS ONLY REQUIRED IF THE MEMBER IS INELIGIBLE OR INCAPABLE OF SIGNING ABOVE.*

Parent or Legal Representative's Name (please print): _____

Parent or Legal Representative's Relation to Member_____

Signature of Parent or Legal Representative _____ Date _____

☐ A copy of the appropriate legal documentation is enclosed.

INCOMPLETE FORMS WON'T BE PROCESSED.
ALL FIELDS ARE REQUIRED UNLESS OTHERWISE SPECIFIED.

Please complete, sign, and submit this form to:
HMSA Privacy Office, P.O. Box 860, Honolulu, HI 96808-0860; Fax (808) 952-7580 on Oahu.

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