

## **REQUEST FOR CONFIDENTIAL COMMUNICATIONS/ALTERNATIVE ADDRESS**

### **SECTION A - Individual requesting change (Please print):**

|                                                    |                   |
|----------------------------------------------------|-------------------|
| Name:                                              | Date of Birth:    |
| Current Address:                                   |                   |
| Telephone:                                         | Member ID Number: |
| Name of Subscriber:                                |                   |
| Employed By (if Dependent, Subscriber's Employer): |                   |
| Relationship to Contract holder:                   |                   |

### **SECTION B - Please read the following, and provide the information requested:**

You have the right to request that we communicate all future information by alternative means or to an alternative location. You have two options when requesting a change:

- **An alternative Address:** This option is if you would like to have future communications sent to an address different than the subscribers (must be 16 or older). You can also call into the customer service to have an alternate address added to your account at: 401.459.5000.
- **Confidential Address:** This option is if you are requesting BCBSRI to change your address and keep it confidential from anyone other than yourself due to the fear of harm. BCBSRI's Privacy Department takes extra protection when this is option is chosen.

**PLEASE NOTE:** As described in our Notice of Privacy Practices, once an alternate/confidential address request ("Request") goes into effect, all of your protected health information will be processed in accordance with your instructions as noted on this form. Therefore, all documents that might contain protected health information about services you receive (such as letters or explanation of benefits) will be addressed to you and not the contract holder.

However, even with your Request, the check for services you receive from a non-participating provider could be sent to you but made payable to the contract holder. In addition, accumulated payment information such as deductible status, which may contain your protected health information, will continue to appear on all future EOBs sent to the contract holder for services rendered by all providers (participating and non-participating).

If you terminate your Request, the restriction will be removed from all of your protected health information that we hold, including protected health information that was previously restricted. Therefore, you should not terminate a request for confidential communications if you remain

**REQUEST FOR CONFIDENTIAL COMMUNICATIONS/ALTERNATIVE ADDRESS**

concerned that disclosure of your protected health information will endanger you. All requests to terminate confidential communications must be done in writing.

**To exercise your right, please pick one of the following:**

☐ I certify that I am requesting a **confidential communication** due to the fact that I reasonably believe that I could be endangered should such communication not be sent to the alternative location or by the alternative means noted on this request.

☐ I request an **alternative address** for all future communications with me at the following alternative location and/or via the following alternative means.

**Please print and please provide full information regarding the confidential or alternative address.**

Confidential/Alternate Address Line 1:

---

Confidential/Alternate Address Line 2:

---

Town/City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Alternative Means: ☐ Phone: \_\_\_\_\_

☐ Email: \_\_\_\_\_

☐ Fax: \_\_\_\_\_

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Return this form via mail to:**  
Legal Services / Privacy Office  
Blue Cross & Blue Shield of Rhode Island  
500 Exchange Street  
Providence, RI 02903

**Return this form via email to:**  
HIPAA\_Concerns@bcbsri.org