CareConnect Healthier Insurance

REQUEST FOR CONFIDENTIAL COMMUNICATION BY ALTERNATIVE MEANS OR ALTERNATIVE LOCATION

Purpose: This Form is intended for use by an individual to exercise his/her right to request communications from CareConnect Insurance Company, Inc. ("CareConnect") by alternative means or at an alternative location.

SECTION A: Member requesting. (Please Print)

Member's Name: ____

Address: ____

Member Identification Number: ______________________ Date of Birth: _________________

Group or Account # on ID card: ____

Phone number where we can reach you to process your request (required) :(_____) ______ - _______

SECTION B: Please read the following and complete the information requested.

You have the right to request that we communicate about all or part of your protected health information (PHI) to an alternative address or by alternative means to avoid endangering you. We will accommodate your request if it is reasonable, you state clearly that failure to communicate your PHI to the alternative address or by alternative means could endanger you, and you provide the alternative address or means for communicating with you and, if applicable, address how payment will be handled. Your confidential communication request will be in effect until you change or revoke it.

We will begin communications by alternative means or to the alternative location within fifteen (15) business days of our receipt of this signed document.

Any communications prior to this date will be delivered using the existing information. If prior to this request, you have authorized the use or disclosure of your PHI, we will revoke that authorization. You may submit a new authorization to use or disclose your PHI.

This form is valid only for the identification number and individual specified above. If the Member's identification number changes, the Member will be required to submit a new request for confidential communication. **This form only applies to communications from us and does not apply to communications you may receive from other entities.**

ALTERNATIVE MEANS:

Please specify: ____

ALTERNATIVE LOCATION:

☐ Alternative Address: ____

In care of
(optional):____

City: ______________________ State: ________________ Zip Code: ________________

☐ Alternative Phone Number: _________________________

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Please specify the reason for your request:

Please specify the information to be covered by the proposed request:

SECTION C: Signature

If this request is from the **Member,** please complete the following: I understand that this request for communication by alternative means or to an alternative location is applicable only to information held by CareConnect and the disclosure by alternative means or location may not be protected. I understand that any request for FAX or EMAIL communication may be intercepted by others and CareConnect is not responsible if such intercepts occur. I attest that I have read the above statements. I request that CareConnect communicate with me about my PHI at the alternative location or by the alternative means provided in Section B.

_________________________ (Print) _________________________ (Signature)

Date: _________________________

If this request is from a **Personal Representative** on behalf of the individual, please complete the following:
I understand that this request for communication by alternative means or to an alternative location is applicable only to information held by CareConnect and the disclosure by alternative means or location may not be protected. I understand that any request for FAX or EMAIL communication may be intercepted by others and CareConnect is not responsible if such intercepts occur. I attest that I have read the above statements. I request that CareConnect communicate with the member about his/her PHI at the alternative location or by the alternative means provided in Section B.

_________________________ (Print) _________________________ (Signature)

Relationship to Individual: ______________________ Date: ______________________

Personal Representative: If you are not the member or parent of the minor member, please attach proof of your relationship to the member. We will require verification of your authority to act on the member's behalf before this request will be considered complete. Please attach copies of your authorization as required by state law to represent the member – for example, health care proxy or guardianship papers.

Please return this completed form by Fax to (516) 706-3829 or
Mail to:
CareConnect Insurance Company, Inc.
Attention: Privacy Officer
2200 Northern Boulevard, Suite 104, East Hills, NY11548

PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS