



Confidential Communication of Health Information

Use this form to ask us to send your or your dependent's protected health information (PHI) to another address. You can do this if:

- You or your dependent has a valid order of protection, or
- You believe you or your dependent would be in danger if we send information to the subscriber's current mailing address, or
- The information is related to a sensitive diagnosis such as mental health, substance abuse, or HIV.
- You are under 18 years old and the services are related to pregnancy, treatment of sexually transmitted diseases, contraception, HIV testing and treatment, alcohol and substance abuse, or outpatient mental health services.

Protected health information is any information, including a member's name, address, date of birth, member ID number, health claims, and other information, that relates to the member's health, health care services or payment for services, and that identifies the individual.

If you have questions or need help, call our Customer Service team at the number on the back of your member ID card or visit nyceppo.com for more information on how to contact us.

INSTRUCTIONS

1. FILL OUT THE FORM CAREFULLY AND COMPLETELY.

Subscriber information: The subscriber is the person who signed up for the insurance (the subscriber).

Confidential communication requested for: Enter the member's information here.

- If you have custody of children under the age of 18, you can ask for a confidential communication for them, too. Include their names on the form.
- You must enclose copies of the legal documents that show you have custody.

2. COMPLETE THE AUTHORIZATION SECTION.

Member signature: You must sign this form before we can process the request.

Personal representative signature: If a personal representative is submitting the request, he or she must sign this form.

A personal representative is a person who, under law, has the authority to act on your or your dependent's behalf to make health care-related decisions.

The request must include written proof (like proof of legal guardianship or power of attorney) with this request. We need to see this to make sure that this person has the right to act on your or your dependent's behalf.

Note that forms, such as a durable power of attorney form, may only give a personal representative a limited right. The right(s) given to the representative must include the ability to request and receive protected health information. This may be done by giving the individual the right to make health care decisions.

3. SEND THE COMPLETED FORM TO:

EmblemHealth
Corporate Compliance Department
P.O. Box 2878
New York, NY 10116-2878

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4. Upon receipt of a valid, reasonable request, New York City Employees PPO (NYCE PPO) has up to three business days to process the request. You will receive confirmation at your alternative address once your request has been processed.

5. **HOW TO REVOKE OR CANCEL A REQUEST.** You can revoke (cancel) this request in writing. The revocation (cancelation) must be in writing, signed and dated, and sent to the address on this form. By sending a letter to revoke your request, you would like to cancel the confidential communication and begin getting mail from us at the subscriber's mailing address.

Send the letter to:

EmblemHealth

Corporate Compliance Department

P.O. Box 2878

New York, NY 10116-2878



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Once you have completed this form, please mail to:

EmblemHealth

Corporate Compliance Department

P.O. Box 2878

New York, NY 10116-2878

SUBSCRIBER INFORMATION

All items marked with an asterisk (*) must be filled out, or we will not be able to process your request.

*Subscriber name: Last		First	Middle Initial
*Subscriber ID number:			
*Subscriber mailing address: (Street or P.O. Box)			Apt. #
City		State	ZIP code

CONFIDENTIAL COMMUNICATION OF HEALTH INFORMATION REQUESTED FOR:

*Member name:	Date of birth:	*Member ID number:
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Include below children and other dependents for whom the confidential communication also applies:

*Member name:	Date of birth:	*Member ID number:
*Member name:	Date of birth:	*Member ID number:
*Member name:	Date of birth:	*Member ID number:
*Member name:	Date of birth:	*Member ID number:

Requested confidential mailing address and phone number:

*Address: Street or P.O. Box			Apt. #
*City	*State	*ZIP code	Phone No:†

† I understand that the phone numbers I provided on this form may be used by EmblemHealth or any of its contracted parties to contact me about my account, my health benefit plan or related programs, or services provided to me.



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Please check one of the following:

You feel that sending communications to the subscriber’s current mailing address places you or your dependent in danger.

Other. If you are asking for a confidential address for another reason, you must explain why below:

Member signature: _____ Date: _____ / _____ / _____

Personal Representative

Printed Name: _____

Relationship to the Member: _____

Personal representative signature: _____ Date: _____ / _____ / _____

Parent Legal Guardian* Power of Attorney* Other*

*You must include documentation that proves you have legal authority to act for the member.

(If applicable, please see instruction sheet.)