

FAX

512 Main Street, Suite 200
P.O. Box 8150
Rapid City, S.D. 57709
Ph: 605-399-7300
Fax: 605-399-7950

To:	Fax:
Attn:	Date:
From:	Pages:
Re:	Case/Cert:
<input type="checkbox"/> Urgent <input type="checkbox"/> For Review <input type="checkbox"/> Please Comment <input type="checkbox"/> Please Reply <input type="checkbox"/> Please Recycle	

Hello,
Following is a Confidential Communication Request form, which when completed will allow us to use alternative means or an alternative location when communicating your Protected Health Information (PHI). Please complete the form and fax back to my attention at 605-399-7950. Below are instructions for completing the form.

Sincerely,

Section A – Print your name, address, and personal information.

Section B – First lines complete by explaining why you are requesting the Confidential Communication.

Second set of lines describe the PHI you want to include in this request.. Example – all of your Personal Health Information and EOB's.

Third set of lines explain how premiums and other payments will be handled. Example – husband will still be responsible.

Bottom of page one and top of page two – Mark the box (s) that apply and give information requested. Example- only communicate PHI when a password is given or send all PHI to a second address and list the address that you would like it sent to.

Page two – Individual's Signature - Sign and Date the form.

CONFIDENTIAL

CONFIDENTIALITY NOTICE: THIS FACSIMILE (INCLUDING ATTACHMENTS) IS COVERED BY THE ELECTRONIC COMMUNICATIONS PRIVACY ACT, 18 U.S.C. SECTION 2510-2521, IS CONFIDENTIAL AND MAY BE LEGALLY PRIVILEGED. IF YOU ARE NOT THE INTENDED RECIPIENT, YOU ARE HEREBY NOTIFIED THAT ANY RETENTION, DISSEMINATION, DISTRIBUTION, OR COPYING OF THIS COMMUNICATION IS STRICTLY PROHIBITED. PLEASE REPLY TO THE SENDER THAT YOU HAVE RECEIVED THE MESSAGE IN ERROR, THEN DELETE IT. THANK YOU



CONFIDENTIAL COMMUNICATION REQUEST

Purpose: This form is used for an individual’s request that we use alternative means or an alternative location when communicating about protected health information.

SECTION A: Individual requesting confidential communication.

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Identification Number: _____ Social Security Number: _____

SECTION B: To the individual—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 by alternative means or to an alternative location to avoid endangering you. We will accommodate your request if (a) it is reasonable, (b) you state clearly that failure to communicate your protected health information by the alternative means or to the alternative location could endanger you, (c) you provide reasonable alternative means or location for communicating with you, and (d) a satisfactory explanation how any applicable premium or other payments will be handled under the alternative means or location you request. We will not investigate the validity of your claim that failure to communication with you by the alternative means or location could endanger you. To exercise this right, please complete this Section B.

Please explain why you request confidential communication about your protected health information by alternative means or to an alternative location:

Please describe the protected health information you want to make subject to confidential communication:

Please explain how any applicable premium or other payments will be handled:

I request that you communicate with me about my protected health information by the following alternative means. Please provide full information on the alternative means you want us to use:

-
- I request that you communicate with me about my protected health information at the following alternative location. Please provide full information on the alternative location:
-
-

INDIVIDUAL'S SIGNATURE.

I attest that failure to communicate about my protected health information by the alternative means or to the alternative location I request could endanger me.

Signature: _____ Date: _____

If this request is by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

Send completed and signed form to:

First Administrators, Inc.
Director of Compliance
512 Main ST, Suite 200
PO Box 8150
Rapid City, SD 57709