blue california
Promise Health Plan

REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

You may use this form to request that Blue Shield of California Promise Health Plan (Blue Shield Promise) communicate your Protected Health Information ("PHI") to a confidential mailing address, email address, or telephone number. If you choose not to use this form, please submit all information requested in this form in writing to Blue Shield Promise at the mailing address, email address, or fax number at the bottom of the form.

Your request will apply only to PHI communicated by Blue Shield Promise and its business associates. Your request may be denied if it cannot be reasonably accommodated. If your request is granted and you later change your address, or if your Subscriber identification number changes, you must resubmit a new request for Confidential Communications by sending a written request to Blue Shield Promise. You may revoke your request for Confidential Communications by sending a written request to Blue Shield Promise at the mailing address, email address, or fax number at the bottom of the form.

1. Individual requesting Confidential Communication of PHI:

Name:

Subscriber ID number:

Phone number:

Date of birth:

Email address:

2. I request that Blue Shield Promise communicate my PHI to me through the following:

☐ Confidential Mailing Address:

☐ Confidential Phone Number:

☐ Confidential Email Address:

3. Signature of individual, parent of minor child, or personal representative:

Signature **Date**

Printed Name:

Legal representatives or guardians

If this form is signed by someone other than the Individual or the parent of a minor, such as a personal/legal representative or guardian, you must also submit documentation establishing your legal authority to act on behalf of the Individual with respect to their healthcare/PHI. Such documentation may include:

1. HIPAA Authorization;
2. Health Care Power of Attorney;
3. Guardianship papers; or
4. Other valid documentation establishing your legal authority to act on behalf of the Individual.

Representative's name (print):

Relationship to Member:

Type of documentation submitted:

Representative's Signature:

You may return this completed and signed form via one of these options:

Mail: Blue Shield of California Promise Health Plan Privacy Office, PO Box 272540, Chico CA, 95927-2540
Email: privacy@blueshieldca.com
Fax: 1-800-201-9020

Blue Shield of California Promise Health Plan complies with applicable state laws and federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, ethnic group identification, medical condition, genetic information, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, mental disability, or physical disability.

You can get this document for free in other formats, such as large print, braille, and/or audio. Call (855) 905-3825 (TTY: 711), 8 a.m. to 8 p.m., seven days a week. The call is free.