Collective Health

Revised 9/25

CONFIDENTIAL COMMUNICATION REQUEST FORM

Collective Health is contracted by your employer-sponsored health plan ("Health Plan") to administer your Health Plan's benefits. Use this form to request from your Health Plan, that your Health Plan, Collective Health, and their business associates communicate your protected health information (PHI) with you by alternative means or at alternative locations. Your Health Plan may also condition the provision of a reasonable accommodation on whether you: 1) provide an explanation of how payments will be handled (when appropriate), and/or 2) specify an alternative address or other method of contact. **Do not use this form to request a change of address.** If you need assistance with a change of address, please contact your employer's HR Benefits Team.

PLEASE UPLOAD THE COMPLETED FORM AS A NEW MESSAGE IN YOUR MY COLLECTIVE PORTAL OR MAIL TO US AT: COLLECTIVE HEALTH, ATTN: PRIVACY OFFICE, 1557 W. INNOVATION WAY, SUITE 300, LEHI, UT 84043.

Section A: The individual who is requesting a confidential communication:

Name	Subscriber #	Date of Birth	
Address	**City**	**State**	**ZIP**
Telephone Number	**E-mail Address (if available)**		

Section B: Please complete the following about the Confidential Communication Request:

Will the failure to communicate your PHI by alternative means or at alternative locations **endanger you**? ▢ **Yes** ▢ **No**

Section C: Please complete the following about the Confidential Communication Request:

I request that all of my PHI be communicated through the alternative means or at the alternative location listed below:

Address	City	State	ZIP
Telephone Number	**E-mail Address (if applicable)**		

If your request is granted, please make note of the following:

1. The request only applies to your current coverage. If any of the information about your coverage changes, including subscriber number or benefits (e.g., dental coverage is added), you must submit a new Confidential Communications Request.
2. This request will replace any previously submitted Confidential Communication Request.
3. The request will expire once your benefits coverage has terminated under your current Health Plan.

Section D: Signature - This document must be signed by the individual, parent of minor child or the individual's personal representative.

I request that my Health Plan, Collective Health, and their business associates communicate with me by alternative means or at alternative locations as specified in Section C above. I understand I will receive a written determination regarding my request. I understand that if I am signing on behalf of a minor child, this request will expire upon the child reaching the age of 18, unless there is proof of continued legal authority.

Signature*	Date: month/day/year

**If you are signing as a power of attorney, legal guardian, executor, or administrator, attach a copy of the legal documents granting authority.*