Confidential Communication Request Form

Western Health Advantage

Mail to: Western Health Advantage Mail Service, Attn: Member Services
PO Box 4457, Portland, OR 97208-4457
Fax to: 916.678.5440
Questions? 916.563.2250 | 888.563.2250 toll-free | 711 TTY

Member Information

First Name _____ Last Name _____ MI _____

WHA Member ID#_____ Date of Birth _____

Address_____ Apt./Unit#_____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

This request is (check one):

❏ New ❏ Modified

❏ TO REVOKE an existing request effective (indicate MM/DD/YY)_____ Skip to Revocation

I am contacting you to request that my protected health information be delivered by alternate means or to an alternate address below for the following reason(s) (check one or both):

❏ My protected health information relates to sensitive services. ("Sensitive services" include sexual and reproductive health care, mental health, sexual assault counseling and care and treatment for alcohol and drug use.)

❏ Disclosure of my protected health information could endanger me or subject me to harassment or abuse. (You will never be asked to explain this.)

Alternative Means or Alternate Address: WHA will send your protected health information to one of the options below. Check the option(s) that are safe for you to receive information. If you check more than one option, indicate a "1" next to your first choice, "2" next to your second choice and so on. Include email or mailing address in the space provided.

option #_____ EMAIL to: _____

option #_____ MAIL to: Address_____ Apt./Unit#_____

City _____ State _____ Zip _____

option #_____ Other: _____

Western Health Advantage is an HMO plan with a Medicare contract. Enrollment in the health plan depends on contract renewal.

I understand and agree to the following:

- WHA will send all of my protected health information to this address.
- I must notify WHA if I wish to change this information. This request is valid until I submit a revocation or a new request.
- This form will affect only communications from Western Health Advantage. If I also wish my employer, physician or anyone outside of Western Health Advantage to make this change, you must contact them directly. (Call WHA Member Services for contact information for these entities).
- This request will only apply to my current membership ID number. If my membership ID number changes, I must submit a new Confidential Communications Request.
- This request will expire eighteen (18) months after my benefits coverage has terminated.

Revocation: If I have indicated this is a **revocation** above, revoke my confidential communications request and use the following address for all of my medical information.

Address_____ Apt./Unit#_____

City _____ State _____ Zip _____

WHA Member Signature _____ Date _____

Print Name _____

WHA Internal Use Only

Date Request Received _____ Date Request Fulfilled/Denied _____

If request was received by phone — Date _____ Time _____

❑ Identification Verified (documents checked) — List documents checked/reviewed_____

Signature of Manager or Supervisor _____

Printed Name _____