# Request for Confidential Communication Instructions

You should complete this form if you believe that **you will be at risk** if UMR and/or the Compass Rose Health Plan and its affiliates communicate with you at the Subscriber's address, or if you are a minor who would like to receive confidential communication under an applicable state or federal law.

Until you advise us of your need for confidential communication, we will continue sending Explanation of Benefits (EOBs) about your care to the Subscriber. In addition, any letters relating to those benefits will be mailed to you at the Subscriber's address. Once we **receive your request for confidential communication**, all EOBs, letters and other written correspondence about your health care benefits will be mailed to the alternative address provided on the enclosed form.

If you request confidential communication, UMR and/or the Compass Rose Health Plan and its affiliates will send all written correspondence and EOBs to you at the new address and/or call you at the alternative phone number provided until you notify us otherwise in writing. If you move, or would like us to send all correspondence to another address, you must fill out the **Request to Revoke or Change Prior Confidential Communication Request Form** — these changes **cannot** be done through the usual enrollment/eligibility process.

**Important:** If you are a guardian or court appointed representative, you **must** attach copies of your authorization to represent the individual in order to obtain access to their Protected Health Information (PHI).

When filling out this form, please:

- Complete all sections entirely (both back and front of form).
- Print information clearly.
- Provide us with the most current information.

**Please note:** we can only process your confidential communication request with respect to benefits administered by UMR and/or the Compass Rose Health Plan and its affiliates. To obtain confidential communication concerning your health benefits not managed by UMR and/or the Compass Rose Health Plan and its affiliates, you must contact the entity that administers those benefits directly.

**Mail completed form to:** UMR, Customer Service Privacy Unit, P.O. Box 8095, Wausau, WI 54402-8095
**Or fax completed form to:** (855) 405-2189

**Please keep a copy of this document for your records.**

# Request for Confidential Communication Form

By completing this form, you are requesting that all health benefits communication from UMR and/or the Compass Rose Health Plan and its affiliates be communicated via the alternate address and/or phone number provided below. The Subscriber will not be permitted to receive or access your information. All information requested below (front and back) must be completed in its entirety in order for this request to be processed.

## 1. Current Information

**Member Name:** _____ **Health Plan Member ID#:** _____

**Phone Number:** _____ **Date of Birth (MM/DD/YYYY):** _____

**Address:** _____

**City:** _____ **State:** _____ **Zip code:** _____

**Relationship to Subscriber:** ○ Self ○ Spouse ○ Child ○ Other (please describe): _____

## 2. Alternate Contact Information

All future communication about your health benefits will be mailed to this alternative address until you notify us in writing that you would like to revoke or change your prior request — this cannot be done during the annual enrollment/eligibility process.

Please indicate the **new address and/or phone number** where you would like to receive all future communication from UMR and/or the Compass Rose Health Plan and its affilates about your health benefits:

**Phone Number:** _____ **Address:** _____

**City:** _____ **State:** _____ **Zip code:** _____

## 3. Signature

Authorized signature of member or legal guardian/personal representative of member, for whom confidential communication is being requested. I authorize UMR and/or the Compass Rose Health Plan and its affiliates to communicate with me at the address and/or phone number listed in the Alternate Contact Information section.

**A. Member**

I acknowledge that by signing this form I have read and understand the above information.

| Member signature | Print member name | Date |
|---|---|---|
| _____ | _____ | _____ |

**B. Legal Guardian or Member Representative**

I acknowledge that by signing this form I have the legal authority to act on behalf of the member or patient, and am attaching the appropriate documentation to this request.

| Guardian/representative signature | Print guardian/representative name | Relationship to member | Date |
|---|---|---|---|
| _____ | _____ | _____ | _____ |