

# Request to Revoke or Change Prior Confidential Communication Request Instructions



You (or your personal representative) previously sent UMR and/or the Compass Rose Health Plan and its affiliates a request for confidential communication relating to your health benefits. Use this form only if you would like to revoke or change the prior request sent to UMR and/or the Compass Rose Health Plan and its affiliates that was made to communicate with you at an alternate address or by alternate means.

If you choose to revoke your prior request for confidential communication, all Explanation of Benefits (EOBs) relating to services after the date you sign and return this form will be mailed to the Subscriber's address. In addition, any letters relating to those benefits will be mailed to you at the Subscriber's address.

If you would like to continue receiving confidential communication, but would like all correspondence to be mailed to a different address, please provide the updated address. All EOBs and letters related to your health benefits mailed after the date of your request will be sent to the new address. UMR and/or the Compass Rose Health Plan and its affiliates will continue to send all correspondence to you at this address until you request to revoke your confidential communication or provide us with another address.

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 to Revoke or Change Prior Confidential Communication Request Form



By completing this form, you are revoking or changing your prior request that all health benefits communication from UMR and/or the Compass Rose Health Plan and its affiliates be communicated via an alternate address, phone number and/or other method. All information requested below (front and back) must be completed in its entirety in order for this request to be processed.

## 1. Current Information

(as stated on prior request for confidential communication)

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. Revoke or Change Prior Request

- I would like to **revoke** my prior request for confidential communication.  
*I understand that by revoking this request, EOBs relating to my care/treatment will be sent to the subscriber. Any other written correspondence about my care/treatment will be sent to me at the subscriber's address.*
- I would like to **revise** my prior request for confidential communication and give UMR and/or the Compass Rose Health Plan and its affiliates a new address and/or phone number.

If you are revising your prior request, 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 affiliates.

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Phone Number: \_\_\_\_\_

## 3. Signature

Authorized signature of member or legal guardian/personal representative of member.

I authorize UMR and/or the Compass Rose Health Plan and its affiliates to communicate with me as indicated above.

### 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
-----------------------------------	------------------------------------	------------------------	------