GEHA

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REQUEST FOR CONFIDENTIAL COMMUNICATIONS BY ALTERNATIVE MEANS OR ALTERNATIVE LOCATIONS

Use this form to request that GEHA communicate with you using a different means or location.

About you, the GEHA member requesting confidential communications

Plan ID Number: _____

Member Name: _____ **Date of Birth:** _____

Address: _____

Telephone Number: _____

Please place a check mark in front of each plan you want this Access request to be applied:

- ☐ GEHA Health Plan
- ☐ GEHA Connection Dental Federal Plan
- ☐ Connection Dental *Plus* Plan
- ☐ CONNECTION Vision Plan

New Contact Information

New Address: _____

_____

New Telephone: _____

Reason for Request: _____

Please complete the following regarding your confidential communications request:

Will the failure to communicate your Protected Health Information through an alternative location endanger you?

☐ Yes ☐ No

Signature and Acknowledgement

- I understand that any request GEHA accepts will be limited to information under GEHA's control, and the request will be communicated to GEHA's Business Associates.
- I have the right to request GEHA terminate the confidential communication to the extent that such termination applies to information created or received after the date of termination, by contacting the Privacy Office at the address below or at privacyofficer@geha.com.

Date: _____

Patient or Legal Representative Signature: _____

Relationship to patient: _____
(i.e. parent, legal guardian, power of attorney, etc.)

NOTE: If the signature is not that of the patient or the parent when the child is a minor, appropriate legal documentation is required to accept the signature.

PHI10/R11
ENR-1495-PHI10
GE-FRM-0219-001

PLEASE RETAIN A COPY FOR YOUR RECORDS AND RETURN THE ORIGINAL SIGNED FORM TO:

ATTN: Confidential Communications Request
GEHA
P.O. Box 21542
Eagan, MN 55121
FAX: 816-257-3283