A UnitedHealthcare Company

Request for Confidential Communication

You should complete this form if you believe that you will be at risk if UMR communicates with you at the Subscriber's address, or if you are a minor who would like to receive confidential treatment under an applicable state or federal law.

Once we receive this request, we will send Explanation of Benefits (EOBs), letters, and other written correspondence about your care to the alternative address that you have indicated on the enclosed form.

Until you advise UMR of your need for confidential communications, UMR will send EOBs about your care to the Subscriber and will send letters and other correspondence to you at the Subscriber's address.

If you request confidential communications, UMR will send all written correspondence and EOBs to you at the address you supply and/or will call you at the alternative phone number you supply. We will continue to do so until you advise us otherwise in writing.

If you would like to revoke your request, you must fill out a new form indicating that you want to revoke your request. If you move or would like UMR to communicate confidentially with you at another address, you must fill out a new form with your new address information. You cannot update your information through the usual enrollment/eligibility process. To provide us with another address or revoke a prior request for confidential communication, you must fill out a new form and send the completed form to the address at the end of this form.

When completing this form, please:

- Complete all sections entirely
- Print information clearly
- Provide us with your most current information

Please note: If you are a guardian or court appointed representative for the individual, you must attach copies of your authorization to represent the individual in order to obtain access to their Protected Health Information.

Please note that we can only process your confidential communication request with respect to benefits administered by UMR. To obtain a confidential communication concerning your benefits not managed by UMR or its affiliates, you must contact the entity that administers those benefits directly.

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Request for Confidential Communication

(at alternative address or by alternative means)

This form is used to request that UMR communicate with you at an alternative address or by alternative means. It must be completed in its entirety to ensure prompt and accurate processing.

SECTION 1: Member's current information

Member name _____

Street address _____ City _____ ST _____ Zip _____

Phone ____-____-____ Date of birth ____/____/____ (MM DD YY) ○ Male ○ Female

Relationship to subscriber ○ Self ○ Spouse ○ Child If other, describe type of relationship _____

SECTION 2: Alternative address

Please indicate the address and/or phone number where you would like to receive all future communication from UMR about your care.

Street address _____ City _____ ST _____ Zip _____

Phone ____-____-____

Please note that if you chose an alternative address, UMR will send all EOBs, letters, and other written communication to this address until you advise us in writing that you would like us to use another address. You cannot change this address through the annual enrollment/eligibility process. You must write to us again to change your address or revoke your request for confidential treatment.

Please indicate the alternative means you would like UMR to use when communicating with you.

○ Please do not send postcards ○ Other *(please describe)* _____

Please provide phone number where we can reach you if we have questions about this form. ____-____-____

(Continued)

SECTION 3: Signature of member and his/her personal representative

Authorized signature of individual, or personal representative of individual, for whom confidential communication is being requested.

I want UMR to communicate with me at the address, phone number, or in the manner that I have indicated on prior page.

Signature of individual _____ Date ___/___/___
MM DD YY

Signature of parent/personal representative *(if applicable)* _____ Date ___/___/___
MM DD YY

Parent/representative's name _____

Street address _____ City _____ ST_____ Zip_____

Phone ___-___-___ Relationship to individual and authority to act for individual _____

Important: A personal representative, including a parent, legal guardian, or executor of an estate, may be required to attach a copy of legal documentation to this request form.

SECTION 4: Subscriber information

Identification number _____ Group number _____

Employer _____ Subscriber name _____

Street address _____ City _____ ST_____ Zip_____

Phone ___-___-___

Please note that by completing this form, you are requesting that communications about your care go directly to you at an alternative address or phone number. The Subscriber will not be permitted to receive or access your information.

PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS

Please return the completed form to: **UMR,** Customer Service Privacy Unit, PO Box 8006, Wausau WI 54402

Fax: **888-742-4179**