Form FEP F14: Confidential Communication Request

Use this form to exercise your right under federal privacy laws to request Blue Cross and Blue Shield of Vermont (BCBSVT) or The Vermont Health Plan (TVHP) to use alternative means or an alternative location when communicating with you about protected health information. This form is intended for BCBSVT Federal Employee Program (FEP) members.

Section A: Member requesting confidential communication.
Member Name: Date of Birth: _____

BCBSVT ID Number: Telephone: _____

E-Mail Address: _____

Subscriber's Current Address: _____
(Please do not enter alternate location information here.)

Section B: Please read the following and complete the information requested (this is a two-page form)
You have the right to request that we communicate your protected health information by alternative means or to an alternative location to avoid endangering you. We will accommodate your request if (a) it is reasonable, (b) you state clearly that failure to communicate your protected health information by the alternative means or to the alternative location could endanger you, (c) you provide reasonable alternative means or location for communicating with you, and (d) a satisfactory explanation how any applicable premium or other payments will be handled under the alternative means or location you request. To exercise this right, please complete this Section B. Attach additional pages if necessary.

I assert that failure to communicate about my protected health information by an alternative means or to an alternative location could endanger me for the following reasons:

_____

_____

_____

Please describe the protected health information you want to be subject to confidential communication:

_____

_____

_____

Please explain how any applicable premium or other payments will be handled:

_____

_____

_____

Please complete the following:

I request that you communicate with me about my protected health information by the following alternative means:

> **Note**: if you would like BCBSVT to be able to contact you through multiple methods, please indicate which contact information is preferred.

Please provide full information on the alternative means you want us to use (e.g., telephone, USPS, e-mail, fax):

_____

_____

_____

_____

Section C: Individual's signature

I attest that all of the above statements on this request and all information furnished by me are true and complete to the best of my knowledge.

Signature: Date: _____

If you are a personal representative, such as a Legal Guardian or an agent acting under a Power of Attorney, you *may* be able to sign on behalf of the Member if the supporting documentation has the required language. This Form shall be accompanied by such supporting documentation for BCBSVT's Legal Department to determine whether authority is granted to authorize this Form.

Personal Representative's Name: _____

Relationship to Member or Authority to act as Personal Representative: _____

Please keep a copy of this document for your records and send the completed Authorization via mail to Blue Cross and Blue Shield of Vermont, Attn: FEP Customer Service, PO Box 186, Montpelier, VT 05601-0186, fax to (802) 225-7700, or email FEPcustomerservice@bcbsvt.com.