

Request for Confidential Communications

Highmark Blue Cross Blue Shield, Highmark Blue Shield & Affiliated Health Plans**

Please return completed form to:

Highmark, Inc
Customer Service
PO Box 890035

Camp Hill, PA 17089 **OR**

Submit on your member app or website by clicking "Send a message" under the Support Tab

Please complete all fields. If information is missing, we will return the form to you for completion. If you need help with this form, contact the Customer Service number listed on your member identification card.

MEMBER INFORMATION - (Please PRINT the information for the member needing confidential communications).

Member Name:		Date of Birth:	
Address:			
City:	State:	Zip:	
Phone (Daytime):	Member ID:		

REQUEST DETAILS - (Please PRINT the following request details.)

<input type="checkbox"/> New Request	<input type="checkbox"/> Update/modify current alternate contact information
Describe the specific reason an alternative means of communication is needed (for new requests only):	
<input type="checkbox"/> End confidential communications as of: ____ / ____ / ____	

ALTERNATE CONTACT INFORMATION - (Please PRINT the contact information which will apply to the request.)

Address:		
City:	State:	Zip:
Phone:	Email:	

I am requesting that Highmark and its subsidiaries and affiliates (Highmark) send communications containing my protected health information (PHI) by alternative means or to an alternative location to avoid a life-threatening situation.

- I understand that Highmark will make a good-faith effort to meet my request provided if:
 - The request indicates that failure to communicate by an alternate method could endanger me;

- The request to communicate by an alternate method is reasonable;
- The request continues to permit Highmark to collect premiums and pay claims as required by contract or law;
- I understand that I must inform Highmark of any changes to my alternate contact information. If my alternate contact information becomes invalid and I cannot be reached, my request will expire;
- I understand that if I cancel my request for confidential communications, or it expires, the restriction will be removed from all my protected health information maintained by Highmark, including information previously protected;
- I understand, that if approved, this request may take a short period to implement, and correspondence may be mailed to the subscriber's address until my account information is updated;
- I understand that during the time the confidential communication is in place; access to the Highmark Member Portal will not be available to me or any other member on the account.
- I understand that any approved request will only apply to communications generated by Highmark and its business associates. To obtain confidential communications with others, such as your doctor, your employer, or other Health Plans, you must contact them directly.

Signature of Member or Legal Representative*

Date

Printed name of Member or Personal Representative

Relationship to Member

***If you are signing this form as a legal representative for the member, you must attach copies of your authorization as required by state law to represent the member (e.g., healthcare power of attorney, healthcare surrogate, or guardianship papers).**

Disclosures:

Benefits and/or benefit administration may be provided by or through the following entities, which are independent licensees of the Blue Cross Blue Shield Association:

Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life, Highmark Senior Health Company, Highmark Care Benefits Inc., or Gateway Health Plan, Inc. d/b/a Highmark Wholecare.

Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company, Highmark Senior Health Company, or Gateway Health Plan, Inc. d/b/a Highmark Wholecare.

PA: Your plan may not cover all your health care expenses. Read your plan materials carefully to determine which health care services are covered. For more information, call the number on the back of your member ID card or, if not a member, call 866-459-4418.

Delaware: Highmark BCBSDE Inc. d/b/a Highmark Blue Cross Blue Shield or Highmark BCBSDE Health Options Inc. d/b/a Highmark Health Options.

West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company, Highmark Senior Solutions Company, or Highmark Health Options West Virginia Inc. d/b/a Highmark Health Options and Highmark Blue Cross Blue Shield. Visit <https://www.highmarkbcbswv.com/networkaccessplan> to view the Access Plan required by the Health Benefit Plan Network Access and Adequacy Act. You may also request a copy by contacting us at the number on the back of your ID card.

Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield.

Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.