Health Partners Plans

Request for Alternative Communications

Use this form to request to receive communications of Protected Health Information (PHI) by alternative means or at alternative locations.

INSTRUCTIONS FOR COMPLETING THIS ALTERNATIVE COMMUNICATIONS FORM

PART 1: Member information. This section should name the Health Partners Plans (HPP) member whose PHI is requested. Print the member's name, birth date, address, telephone number and Member ID number.

PART 2: Alternative means of communication. This form is used by an individual who wants Health Partners Plans to communicate with him/her using an alternative means due to the risk of endangerment. Health Partners Plans will try to accommodate reasonable requests if provided with a reasonable alternative means or location for communicating. This form should not be used for permanent address changes.

PART 3: Review and approval. The *member's* signature is required. If the member is incapable of signing, a personal representative may sign on the member's behalf. Parents or guardians of minors will be confirmed using information from the state. A personal representative such as an executor or someone with a power of attorney may sign his or her name in the member's place. The legal documents proving the authority of the personal representative to act for the member **MUST** be attached or on file at HPP; otherwise the personal representative's signature will be invalid and this form will **NOT** be processed.

Complete ALL sections. If information on this form is not complete Health Partners Plans will return the form and will not consider this request until it has received complete information.

CONTACT INFORMATION

RETURN YOUR FORM(S) TO THE ADDRESS LISTED BELOW.

If you have any questions or need assistance in completing this form, call the Member Relations telephone number on the back of your identification card or write to:

HIPAA Privacy Services
Health Partners Plans
901 Market Street, Suite 500
Philadelphia, PA 19107

or

Fax: 267-515-6666

Request for Alternative Communications

PART 1: Please PRINT the following information	
Member Name:	**Date of Birth:**
Address:	**City/ZIP:**
Member ID #:	**Telephone: ( )**

PART 2: Alternative Communication Request

Describe the protected health information you would like subjected to alternative communication.___

_____

_____

_____

☐I request that Health Partners Plans communicate with me about my protected health information by the following alternative means. Provide full information on the alternative means you want used by Health Partners Plans._____

_____

_____

☐I request that you communicate with me about my protected health information at the following alternative location. Provide full information on the alternative location. _____

_____

PART 3: Signature

This form is used by an individual who wants Health Partners Plans to communicate with him/her using an alternative means due to the **risk of endangerment**.

Your request for communication by alternative means is applicable to the information **maintained by Health Partners Plans only**. If you would like an alternative means of communication from any other entity you must contact that entity. **You have 30 business days to return this request to Health Partners Plans. In the event this form is not received, the information above will be used for *ALL* communication from Health Partners Plans. Termination of this request must be submitted in writing unless indicated below.**

ALL communication from Health Partners Plans will be provided as indicated below.

I have read and understand the above information:

Member or personal representative name: _____

Signature:_____

Date:_____

If personal representative, state relationship to member:_____

Note that, if not already provided, we will require verification of the authority of a personal representative such as a copy of a health care, general or durable power of attorney before this request will be considered complete. If this request is made by a parent/guardian, complete the following: Member/participant is a minor ___ years of age. If you are making this request on behalf of a minor child, we may require additional information such as a court order or other documentations that shows custody or other legal document showing the authority of the legal representative to act on the member's behalf before this request is considered complete.