

**Group Health Plan's Response to Request for Confidential
Communications of Protected Health Information**

To: _____ Date of this Notice: _____

Your request for confidential communication of group health plan protected health information (PHI) has been reviewed and the following determination has been made:

ÿ Request Granted

Your request for confidential communications of PHI has been granted in accordance with your request.

ÿ Request Denied

Your request for confidential communications of protected health information has been denied because:

_____ The Plan cannot accommodate the request.

_____ Your request did not certify that disclosure of all or part of the PHI to which the request pertains could endanger you.

ÿ Additional Information Needed

Your request for confidential communications of PHI has been received; however, because information was missing we cannot process your request at this time. If you submit the following information, then your request will be granted:

_____ Please specify how payment of benefits under the Plan should be handled: _____

_____ Please specify either an alternative means of contact or delivery or an alternative location of delivery.

Alternative Means of Contact or Delivery: _____

Alternative Location or Delivery: _____

Signature _____ SSN _____

Date _____

Please return this form to:

Benefit Services Manager
Department of Human Resource Services
Benefit Services Division
2033 K Street, NW, Suite 220
Washington, DC 20052