

**Plan Member Request for Alternative Method for Confidential Communication of Protected Health Information**

Member Name (PLEASE PRINT): \_\_\_\_\_ SSN: \_\_\_\_\_

Mailing Address: Street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Complete This Section**

I request that I receive communications of my group health plan PHI from the Plan, as follows:

Alternative Means of Contact or Delivery \_\_\_\_\_

OR

Alternative Location of Delivery \_\_\_\_\_

- I request that the following specific communications be covered by the above request: \_\_\_\_\_

\_\_\_\_\_

- I am making this request because: \_\_\_\_\_

\_\_\_\_\_

**Important Information About Your Request**

I understand that I may request an alternative method of communication for group health plan protected health information (PHI) *only if* the disclosure of all or part of the information to which this request pertains could endanger me.

I also understand that the Plan will agree to all reasonable requests, but will condition this accommodation on, when appropriate, information as to how payment, if any, will be handled and my specifying below an alternative means or alternative location.

Date \_\_\_\_\_ Signature \_\_\_\_\_

PLEASE MAIL TO:

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

For Plan Use Only: Date Request Received \_\_\_\_\_

By: \_\_\_\_\_