Horizon NJ Health

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Use this form if you wish to establish an alternate means of communication with Horizon NJ Health because the release of Protected Health Information (PHI) could endanger you.

Read instructions on PAGE 3 before completing this form. ALL FIELDS MUST BE COMPLETED.
Please print legibly, except where signature is required.

Please complete the information below, sign in the space provided and return to Horizon NJ Health, Attn: HIPAA Team, 1700 American Blvd. Pennington, NJ 08534 or via fax at 609-538-1574.

SECTION A- MEMBER INFORMATION

Name (Subscriber Dependent): ____ Date of Birth:_____/_____/ _____
MM DD YYYY

Subscriber name____ Subscriber Identification # ______________________________

Address (on file): ____

City:____State:_________ZIP: _____________

SECTION B- CONFIDENTIAL COMMUNICATION REQUEST OR MODIFICATION

Please choose one of the following:

- ☐ **Initial Request**- This form is an initial Confidential Communication Request. (Complete entire form.)
- ☐ **Modify a previous request**- This form is modifying (i.e, changing the alternative address) a previously approved Confidential Communication Request. (Complete entire form.)

Will the failure to communicate your PHI through an alternative location endanger you? If you select "no" please call the customer service number on the back of your identification card to request address change.

☐ YES

☐ NO

SECTION C- ALTERNATIVE ADDRESS INFORMATION

I, _____________________________ request confidential communication of my private information by Horizon NJ Health and its business associates, to be sent to an alternate location as otherwise agreed below. I understand that this applies only to communications from Horizon NJ Health to me.

Do you have an alternate address you wish us to use: Yes No

If Yes, provide the address below. If No, Horizon NJ Health will keep all your mail and you will have to contact the Privacy Center of Excellence to retrieve it.

Alternative Location:

Street Address: ____

City:____State:_________ZIP: _____________

Password:_______________________________(Must be 4 to 10 characters, letters or numbers, and a password only you will know.)

Is there other means we may use to contact you (e.g. phone or email) if necessary?

Phone Number: ______________________________________Email Address:____________________________________

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SECTION D – SIGNATURE

I request that Horizon NJ Health release my PHI as specified in Section C above. I understand that Horizon NJ Health is under no obligation to agree to my request. I understand I will receive written determination regarding my request. I understand that if I am signing on behalf of a minor child, this request will expire upon the child reaching the age of 18, unless there is proof of legal guardianship.

____ Date: _______/________/__________

Signature of Member OR Personal Representative* MM DD YYYY

____

Print Name

*Check one. If the requestor is other than the member, the requestor must sign the form and attach documentation showing authorization to act on behalf of the member, unless the requestor is already an established personal representative with full authority.

Products are provided by Horizon NJ Health. Communications are issued by Horizon Blue Cross Blue Shield of New Jersey in its capacity as administrator of programs and provider relations for all its companies.

INSTRUCTIONS

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

General Instructions: This form should be completed when a member wishes to establish an alternate means of communication with Horizon NJ Health. You have the right to request an alternative location if the disclosure of your Protected Health Information could endanger you. Please use this form to initiate a request of this nature. THIS FORM IS NOT TO BE USED TO CHANGE AN ADDRESS ON FILE.

We will accommodate your request if all of the following criteria are met:

1.) Your request is reasonable;
2.) You clearly state that failure to honor your request could endanger you;
3.) You provide reasonable alternative means or location for communicating with you

Section A. Member Information
This section requests information related to the member for which the confidential communication is being requested. In the subscriber field, write the name of the policyholder. The policy holder is the individual who holds the insurance policy with Horizon NJ Health. Since this information is used for both identification and verification purposes the information included in this section should match the most current information for the member/subscriber that Horizon NJ Health has on file. Please be aware that this form may be denied if the information on the form does not match the information in our records.

Section B- Confidential Communication Request or Modification
The requestor should indicate if this is the first instance of making this type or request or if this is a modification of a previously processed request. The requestor must indicate that the release of PHI would result in harm or endangerment. Horizon NJ Health will not investigate the validity of your claim that failure to communicate with you by the alternate means or location could endanger you.

Section C- Alternate Contact Information
The information given will provide Horizon NJ Health an alternate means of communications with the member. All correspondence intended for the member will be directed to the alternate address on the form. If no address is provided or cannot be provided, correspondence will be received by Horizon NJ Health's Privacy Center of Excellence. The member must contact the Privacy Center of Excellence to retrieve it. You may contact the Privacy Center of Excellence by mail: Privacy Center of Excellence PP-16F, Horizon NJ Health, PO Box 420, Newark, NJ 07101-9968.

Members are asked to provide a password to better enable Horizon NJ Health to control access to their private information. This password will be required from the caller during the verification process. A phone number or an email address can be provided by the member for other communications initiated by Horizon NJ Health.

Section D- Signature
Signature of the person making this request.

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Mail this form to:

Horizon NJ Health
Attn: HIPAA Team
1700 American Blvd.
Pennington NJ 08534

Or Fax to: (609) 538-1574

HNJH_HIPAA_Team@horizonblue.com

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