Community Health Plan of Washington
Request for Confidential Communications

You have the right to request an alternative means of communication (e.g., regular mail, email, telephone, facsimile) of your protected health information (PHI) or communication of your PHI to an alternate location. This request for communications by alternative means or to an alternate location is applicable only to the information held by Community Health Plan of Washington (CHPW) and disclosure by alternative means may not be protected and could endanger me. Confidential communication of PHI covered under this request includes (but is not limited to):

- An explanation of benefits (EOB) notice.
- Information about an appointment.
- A claim denial.
- A request for additional information about a claim.
- The name and address of a provider, a description of services provided, and any other visit information.

1. **Member Name:** ________________________________ **Date of Birth:** _____________

Member ID Number: _____________________ **Date of Request:** _________

Member Address: ____

Member email: ____

Member Phone: __________________ **Member Fax:** __________________

Choose one: ☐ Ok to leave message with detailed information.
☐ Leave message with call-back number only.

2. Check only one box below to tell CHPW the specific PHI to which this request applies:

☐ **All PHI about the sensitive/protected services** I receive using my health insurance, including where and when I receive health care be sent directly to me by the alternative means or to the alternate location as outlined in Section 2 below.

☐ **All information about the health care I receive** using my health insurance, including where and when I receive care be sent directly to me by the alternative means or to the alternate

location as outlined in Section 2 below because disclosure of all or part of this information could lead to harm or could subject me to harassment or abuse. **(You will never be asked to explain why you feel this way.)**

☐ **A specific date of service**: ____________________________

☐ **A specific period of time: From:** __________ **To:** __________

3. I request that communications containing any of the above information be sent to me as available as follows:

☐ Email to: ____

☐ Text message to: _________________________________

☐ Phone call to: ____________________________________

☐ U.S. Mail to: ____

4. IMPORTANT: the following MUST be completed:

4a. If a communication cannot be sent in the above formats, or if you want information by U.S. mail, provide the address below:

____

4b. Is there a phone number or email to use if there are questions about this request?

____

5. I understand that it may take up to three business days from the date of receipt of this form for CHPW to process the request. I further understand that I may make this request by telephone to the customer service number listed below.

______________________________	_____________________________	________________
Printed Name	**Phone**	**Date**

Signature

☐ Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (e.g., Power of Attorney). This only applies if someone other than the member signed above.

Telephone Number of Personal Representative: ___________________________________

Personal Representative's relationship to the member: _____________________________

4. Send the completed, signed request to:

Community Health Plan of Washington
Attn: Customer Service Department
1111 3rd Ave, Ste. 400
Seattle, WA 98101
Fax: (206) 521-8834
Email: CustomerCare@chpw.org

If you have any questions or to obtain a full notice of your privacy rights, contact CHPW's Customer Service department at the following

If you are a Washington Apple Health (Medicaid) Member	If you are a CHPW Medicare Advantage Member
Contact Customer Service toll-free at 1-800-440-1561, Monday – Friday, from 8am to 5pm. If you are hearing or speech impaired, please call TTY 711 (toll-free). The notice is also available online at: https://www.chpw.org/member-center/member-rights/	Contact Customer Service toll-free at 1-800-942-0247, 7 days a week, from 8am to 8pm. If you are hearing or speech impaired, please call TTY 711 (toll-free). The notice is also available online at: https://medicare.chpw.org/member-center/member-rights/

If you are a Cascade Select Member Contact Customer Service toll-free at 1-866-907-1906, Monday – Friday, from 8:00 a.m. to 5:00 p.m. If you are hearing or speech impaired, please call TTY 711 (toll-free). The notice is also available online at: https://individualandfamily.chpw.org/member-center/member-rights/	