## Request for Confidential Communication

You should complete this form if you believe that **you will be at risk** if UMR and/or the Compass Rose Health Plan and its affiliates communicate with you at the Subscriber's address, or if you are a minor who would like to receive confidential communication under an applicable state or federal law.

Until you advise us of your need for confidential communication, we will continue sending EOBs about your care to the Subscriber. In addition, any letters relating to those benefits will be mailed to you at the Subscriber's address. Once we **receive your request for confidential communication**, all Explanation of Benefits (EOBs), letters and other written correspondence about your health care benefits will be mailed to the alternative address provided on the enclosed form.

If you request confidential communication, UMR and/or the Compass Rose Health Plan and its affiliates will send all written correspondence and EOBs to you at the new address and/or call you at the alternative phone number provided *until you notify us otherwise in writing*. If you move, or would like us to send all correspondence to another address, you must fill out the **Request to Revoke or Change Prior Confidential Communication Request Form**—these changes **cannot** be done through the usual enrollment/eligibility process. Please complete and return the new form to the following address:

UMR
Customer Service Privacy Unit
P.O. Box 8095
Wausau, WI 54402-8095

**Important**: If you are a guardian or court appointed representative, you **must** attach copies of your authorization to represent the individual in order to obtain access to their Protected Health Information (PHI).

When filling out this form, please:

– Complete all sections entirely (both front and back of form);
– Print information clearly; and
– Provide us with the most current information.

**Please note**: we can only process your confidential communication request with respect to benefits administered by UMR and/or the Compass Rose Health Plan and its affiliates. To obtain confidential communication concerning your health benefits not managed by UMR and/or the Compass Rose Health Plan and its affiliates, you must contact the entity that administers those benefits directly.

This form is used to **request** that UMR and/or the Compass Rose Health Plan and its affiliates communicate with you at an alternative address or by alternate means. It must be completed in its *entirety* (back and front of form) to ensure prompt and accurate processing. **Please print.**

**SECTION 1:** **Member's Current Information**

**Member Name**: ______________________________ **Male:** ☐ **Female:** ☐

**Address**: __________________________________________________ **City**: __________________ **State**: ______ **Zip code**: ____________

**Phone Number**: ( ) _______ - _________________ **Date of Birth**: ____________________ (MM/DD/YYYY)

**Relationship to Subscriber**: Self: ☐ Spouse: ☐ Child: ☐ If other, please describe relationship: ______________________________

**SECTION 2:** **Alternative Address**

***Reminder**: All future communication about your health benefits will be mailed to this alternative address **until you notify us in writing** that you would like to revoke or change your prior request—this cannot be done during the annual enrollment/eligibility process.*

Please indicate the **new address and/or phone number** where you would like to receive all future communication from UMR and/or the Compass Rose Health Plan and its affiliates about your health benefits:

**Address**: __________________________________________________ **City**: __________________ **State**: ______ **Zip code**: ____________

**Phone Number**: ( ) _______ - _______________

*Phone number where we can reach you if we have questions about this form:* ( ) _______ - _______________

Please indicate the **alternative means** you would like UMR and/or the Compass Rose Health Plan and its affiliates to use when communicating with you:

☐ **Other** (please describe): ____________________________________________________________

**SECTION 3:** **Signature of member or his/her personal representative.**

Authorized signature of the member, or personal representative of the member, for whom confidential communication is being requested:

*I want UMR and/or the Compass Rose Health Plan and its affiliates to communicate with me at the address and/or phone number, or in the manner requested, as listed above.*

**Member's Signature**: ______________________________________________________________ **Date**: ________________________

\- OR -

**Signature of Parent/Personal Representative (if applicable)**: ______________________________________ **Date**: ________________________

**Parent/Representative's Name** (please print): ____________________________________________________

**Address**: __________________________________________________ **City**: __________________ **State**: ______ **Zip code**: ____________

**Phone Number**: ( ) _______ - _________________ **Relationship to member and authority to act for individual**: ______________________

**Important**: Any personal representative—including a parent, legal guardian or executor of an estate—may be required to attach a copy of legal documentation to this request form.

## SECTION 4: Member Identification

**Health Plan Member ID#**: ______________________________ **Group Number**: 76-411449

**Member Name**: ______________________________________ **Employer**: ____________________________________________________

**Address**: ___________________________________________________ **City**: __________________ **State**: ______ **Zip code**: ______________

**Phone Number**: (    ) _______ - _________________

*By completing this form, you are requesting that all communication regarding your health benefits be mailed directly to you at an alternative address and/or phone number. The Subscriber will not be permitted to receive or access your information.*

**– PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS –**

Please return the completed form to:

**UMR**
**Customer Service Privacy Unit**
**P.O. Box 8095**
**Wausau, WI 54402-2189**

Fax: (855) 405-2189

Date form completed / revised: ____________________________ (MM/DD/YYYY)