UMR
A UnitedHealthcare Company

COMPASS ROSE HEALTH PLAN

Request to Revoke or Change Prior Confidential Communication Request

You (or your personal representative) previously sent UMR and/or the Compass Rose Health Plan and its affiliates a request for confidential communication relating to your health benefits.

Use this form **only** if you would like to **revoke or change the prior request** sent to UMR and/or the Compass Rose Health Plan and its affiliates that was made to communicate with you at an alternate address or by alternate means. Please complete and return to attached form to the following address:

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

If you choose to **revoke your prior request** for confidential communication, all Explanation of Benefits (EOBs) relating to services after the date you sign and return this form will be mailed to the Subscriber's address. In addition, any letters relating to those benefits will be mailed to you at the Subscriber's address.

If you would like to continue receiving confidential communication, but would like **all correspondence to be mailed to a different address**, please provide the updated address. All EOBs and letters related to your health benefits mailed after the date of your request will be sent to the new address. UMR and/or the Compass Rose Health Plan and its affiliates will continue to send all correspondence to you at this address until you request to revoke your confidential communication or provide us with another address.

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 **revoke or change the prior request** sent to UMR and/or the Compass Rose Health Plan and its affiliates, which was made to 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 (as stated on prior Request for Confidential Communication).

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: Please indicate whether you want to revoke or change your prior request for confidential communication.

☐ I would like to **revoke** my prior request for confidential communication.
I understand that by revoking this request, EOBs relating to my care/treatment will be sent to the member. Any other written correspondence about my care/treatment will be sent to me at the member's address.

☐ I would like to **revise** my prior request for confidential communication and give UMR and/or the Compass Rose Health Plan and its affiliates a new address and/or phone number.

If you are revising your prior request, please indicate the new address and/or phone number where you would like to receive all future communication about your health benefits from UMR and/or the Compass Rose Health Plan and its affiliates.

Address: _____ **City**: _____ **State**: _____ **Zip code**: _____

Phone Number: ( ) _____ - _____

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

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: _____

Address: _____ **City**: _____ **State**: _____ **Zip code**: _____

Phone Number: ( ) _____ - _____

– 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)