HMA
HEALTHCARE MANAGEMENT ADMINISTRATORS

REQUEST FOR CONFIDENTIAL COMMUNICATION FORM

Please return this form to Healthcare Management Administrators (HMA) by one of these methods:

Mail: HMA Customer Care Team
PO Box 85008
Bellevue, WA 98015

Fax: 1-866-458-5486

SECTION 1 – PATIENT INFORMATION	
Patient's Name:	Phone Number: ( )
Address:	
Member ID Number:	Group Number:

SECTION 2 – NATURE OF REQUESTED RESTRICTION AND CONDITIONS GOVERNING REQUEST

I represent that I could be endangered if my Group Health Plan ("Plan") fails to communicate my protected health information by an alternative means or at an alternative location. _____ [Please initial]

I request my Plan or HMA communicate with me regarding my protected health information in the following alternative methods (select one):

- ☐ Please contact me at this telephone number instead of my home number: (_____)_____
- ☐ Please contact me at this mailing address instead of my home mailing address:
  _____
- ☐ Other method – please specify: _____

Your Plan or HMA is required to honor only *reasonable* Requests for Confidential Communication per the Standards for the Privacy of Individually Identifiable Health Information (often called the "Privacy Rule"). Your Plan or HMA may grant your request with the following conditions:

- You must provide information on how payments will be handled; and
- You must specify an alternative address or other method of contact.

Please note: When a Request for Confidential Communication has been approved, Explanation of Benefits (EOB) will no longer be available electronically. You will receive paper EOB by regular US Postal Service mail on a monthly basis.

SECTION 3 – PATIENT'S SIGNATURE
(Required)

_____
(Printed Name)

_____ _____
(Signature) (Date)

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SECTION 4 – TO BE COMPLETED BY GROUP HEALTH PLAN OR HMA
This Request for Confidential Communication has been reviewed by your Group Health Plan or HMA and is: ☐ Accepted ☐ Denied (Request cannot be reasonably accommodated) If accepted, this restriction becomes effective on this date: _____ Comments: _____ _____ _____ _____ _____ (Signature of Plan or HMA Representative) (Date)