HealthSpring℠

CONFIDENTIAL COMMUNICATION REQUEST FORM

Use this form to either request HealthSpring or one of its Business Associates to communicate with you at an alternative location or by alternative means or to terminate or modify a previously granted Confidential Communication request.
You must complete all the fields on this form.

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

1. Your request is reasonable;
2. You clearly state that our failure to honor this request could put you in danger.
3. You provide a location or another reasonable alternative for us to communicate with you, and;
4. You provide a reasonable explanation of how payments (if applicable) will be handled if the alternative location is used.

DO NOT USE THIS FORM TO REQUEST A CHANGE ADDRESS

If you need assistance in completing this form, or with a change of address, please call the Customer Service number listed on your Member Identification Card.

WHEN COMPLETED AND SIGNED PLEASE MAIL TO YOUR CORRESPONDING PLAN'S ADDRESS BELOW:

Medicare Advantage Plan:
HealthSpring
Medicare Advantage Privacy Rights Intake and Management
PO Box 24207
Nashville, TN 37202

Medicare Prescription Drug Plan:
HealthSpring
Medicare Prescription Drug Plan
PO Box 269005
Weston, FL 33326-9927

Section A Confidential Communication Request or Modification/Termination of Previous Request

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.)

☐ **Terminate a previous Request:** This form is terminating a previously approved Confidential Communication Request. (Complete Section B and proceed to Section D.)
Enter date to terminate previous request (month/day/year): _____

Section B The individual for whom communication at an alternative location is being requested. Please complete the following:

First Name _____ Last Name _____ Group Number _____

Social Security Number _____ Date of Birth _____ Identification\Subscriber Number _____

Address _____ City _____ State _____ Zip _____

Area Code & Telephone Number _____ Email Address (if available) _____

Section C Please complete the following about the confidential communication request:

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

I request that all of my PHI be communicated at the alternative location listed below:
Alternative Location:

Street Address: _____

City: _____ State: _____ Zip: _____ Phone number: _____

Please indicate how any payments (if applicable) will be handled using the alternative location that you request.

_____

_____

_____

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If your request is granted, please make note of the following:

1. The request only applies to your current coverage. If any of the information about your coverage changes including Group or Subscriber number, benefit coverage changes (i.e., dental coverage is added), you must submit a new Confidential Communications Request.
2. The request will expire eighteen (18) months after your benefits coverage has terminated.
3. HealthSpring and its Business Associates are only responsible for the PHI that they release to the alternative address you have designated in Section C.

Section D Signature: This document must be signed by the individual, parent of minor child or the individual's Personal Representative.

I request that HealthSpring release my PHI as specified in Section C above. I understand that HealthSpring is under no obligation to agree to my request. I understand I will receive a 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.

Signature _____ Date: month/day/year _____

Section E If Section D is signed by a Personal Representative, please complete the information below:

If you are signing as a Power of Attorney, Legal Guardian, Executor or Administrator, please attach a copy of the legal documents. You do **NOT** have to attach copies of these documents if they are already on file with HealthSpring.

Personal Representative's Name _____ Relationship to Individual _____

Personal Representative's Address _____ City _____ State _____ Zip _____

Personal Representative's Area Code & Telephone Number _____

Personal Representative's E-mail Address (if available) _____

Any changes to the format, content or branding of this form are strictly prohibited without review and approval of the Privacy Office.