



Confidential Communication

You have the right to request that we communicate with you on a confidential basis by requesting an alternative means or an alternative location to receive our communications. For instance, you may request that we send your Explanation of Benefits only to your work address. We will accommodate all reasonable requests for confidential communication. If you wish us to contact you at an address or phone number other than your home address or telephone, please provide us with the following information:

Section I: Member/Dependent Information- All fields are mandatory and should be completed in order for the form to be processed timely. (Please Print Clearly & Legibly)

Name _____ Date of Birth ____ / ____ / ____

Address _____

Phone _____ E-mail Address _____

Section II: OSU Employee/Subscriber Information

Name _____

Trustmark Member ID Number _____

Address to receive communications:

Phone number to receive communications:

Please describe in as much detail as possible any other alternative means you request we use in communication with you or any other alternative location not detailed above. You may use a separate sheet of paper, if necessary.

Do you believe that without this alternate communication, the disclosure of some or all of your information could endanger you? Yes No

This form must be accompanied by signature page on the second page of this form.



Signature (Digital/electronic Signature is not acceptable)

Date

Print Name

If you are a personal representative of the member, please provide documentation or explanation of your authority to act for the member and attach to this form.

Please note that we will not process any requests that are not signed by you or your personal representative. Digital/electronic signature is not accepted.

For this Confidential Communication form to be valid, it must be filled out accurately and completely.

Return this form to the HIPAA Privacy Officer, OSU Health Plan, Inc., 700 Ackerman Road, Suite 1007, Columbus, Ohio 43202 or fax to (614) 292-8366

FOR OSU HEALTH PLAN PRIVACY OFFICE USE:

APPROVED BY: _____
OSU Health Plan HIPAA Privacy Officer

DATE: _____

REASON DENIED: _____

DENIED BY: _____
OSU Health Plan HIPAA Privacy Officer

DATE: _____