THE OHIO STATE UNIVERSITY
HEALTH PLAN

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 on this form are mandatory and must be completed for the form to be processed timely. **Please Print Clearly & Legibly**

Name____ Date of Birth_____/_______/________

Address____

Phone________________________________ E-mail Address____

Section II: OSU Employee/Member Information

Name____

Luminare Member ID Number ____

Address to receive communications:

____

____

____

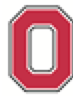
Phone number to receive communications:

____

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.



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____ ______________________
Member Signature or Personal Representative Signature **Date**

____
Print Name

If Personal Representative, source/document, such as Healthcare Power of Attorney, of authority to act for Member is required.

Please note that we will not process any requests that are not signed by you or your personal representative.

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

Return this form to: The 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:______________________________________ **DATE:**______________________
OSU Health Plan HIPAA Privacy Officer

REASON DENIED:____

DENIED BY:______________________________________ **DATE:**______________________
OSU Health Plan HIPAA Privacy Officer