BlueCross BlueShield of New Mexico

# Request form to limit how we use or share your Protected Health Information (PHI)

**Please fill out this form if you want us to limit how we use or share your PHI when it comes to health care treatments, payments or operations. You also can ask us to limit how we share your PHI with people who take care of you or pay for your care**

- You should know that we do not have to agree to your request.
- If we do agree, we will limit how we use or share your PHI. But we still may use or share any PHI that is needed for emergency treatments or when the law says we can.
- We will send you a letter to let you know what we decide.

- **If we have agreed to limit how we use or share your PHI:**
    - You may write to us at any time to ask us to stop limiting how we use or share it.
    - We may send you a letter at any time to let you know that we no longer agree to limit using or sharing your PHI.
        - If you agree with us, we will no longer put a limit on how we use or share your PHI.
        - If you do not agree with us, we will stop putting a limit on how we use or share any of the PHI that we made or got after the date we wrote you saying that we no longer agreed to stop using it.

To learn more or if you still have questions, call the Customer Care Center at 866-689-1523. If you have hearing or speech loss, call the text telephone (TTY) line at 800-874-9426.

Sincerely,

Customer Advocate

**If you want to ask us to limit how we use or share your PHI, please fill out Parts A and B below. Then mail the form back to us in the envelope that came with it.**

**Part A: Tell us about the person whose PHI you are asking us to limit using**

Member name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone number: _____

Date of birth: _____

Member ID number: _____

**Part B: Give us details about what PHI you want us to limit**

_____

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Please tell us what limits you want us to put on your PHI.

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**Part C: Member's signature**

| | |
|---|---|
| **Member's signature** (If member is a minor, parent should sign) | **Date** |

**Chosen legal representative or guardian**

If the member has chosen someone to sign this form for him or her, that person needs to fill out the lines below. And please attach a copy of a Health Care Power of Attorney, a court order or other papers that show that this person may act for the member.

Legal representative or guardian (print full name):_____

Legal relationship to the member: _____

Signature: _____ Date: _____

Please return completed form to:

**Blue Cross and Blue Shield of New Mexico**
**P.O. Box 660044**
**Dallas, TX 75266-0044**

**Or email to: OCA_SSD@bcbstx.com**

# To ask for auxiliary aids and services or materials in other formats and languages at no cost, please call **1-866-689-1523** (TTY/TDD: **711**).

Blue Cross and Blue Shield of New Mexico complies with applicable federal civil rights laws and does not discriminate on the basis of health status or need for services or race, color, national origin, age, disability, sex, ancestry, spousal affiliation, sexual orientation and/or gender identity. Blue Cross and Blue Shield of New Mexico does not exclude people or treat them differently because of health status or need for services or race, color, national origin, age, disability, sex, ancestry, spousal affiliation, sexual orientation and/or gender identity.

Blue Cross and Blue Shield of New Mexico provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats and more)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator.

If you believe that Blue Cross and Blue Shield of New Mexico has failed to provide these services or discriminated in another way on the basis of health status or need for services or race, color, national origin, age, disability, sex, ancestry, spousal affiliation, sexual orientation and/or gender identity, you can file a grievance with: Civil Rights Coordinator, Office of Civil Rights Coordinator, 300 E. Randolph St., 35th floor, Chicago, Illinois 60601, **1-855-664-7270**, TTY/TDD: **1-855-661-6965** or Fax: **1-855-661-6960** You can file a grievance in person, by mail or fax. If you need help filing a grievance, a Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

**1-800-368-1019**, **1-800-537-7697** (TDD)

Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-710-6984 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-710-6984 (TTY: 711).

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad, saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, kojį' hódíilnih 1-855-710-6984 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-710-6984 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-710-6984 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-710-6984 (TTY: 711)。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-710-6984 (رقم هاتف الصم والبكم:711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-710-6984 (TTY: 711) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-710-6984 (TTY: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-855-710-6984（TTY: 711）まで、お電話にてご連絡ください。

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-710-6984 (ATS: 711).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-855-710-6984 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-710-6984 (телетайп: 711).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।

1-855-710-6984 (TTY: 711) पर कॉल करें।

هجوت: رگا هب نابز سرافی وگتفگ می دینک، تلایهست نابزی هب تروص ناگیار اربی امش‌مهارف می دشاب. اب 1-855-710-6984 (TTY: 711) سامت دیریگب.

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-855-710-6984 (TTY: 711).