BlueCross BlueShield of New Mexico

Confidential Communication Request Form

Do you believe that you would be in danger if your Protected Health Information (PHI) were sent to your current address?

☐ ***Yes*** ☐ ***No***

If you answered yes, fill out and return this form. This form asks Blue Cross and Blue Shield of New Mexico (BCBSNM) or our Business Associates to deliver PHI to you at an alternative (other) address or by other means.

You may also fill out this form to end or change an existing Confidential Communication Request.

You must fill out all the fields on this form.

BCBSNM will process your initial request if all of the following 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 an address 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 AN ADDRESS CHANGE

If you need help filling out this form, or with a change of address, please call Member Services at **1-866-689-1523** (TTY: **711**).

WHEN COMPLETED AND SIGNED, PLEASE MAIL TO:

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

Or email to: OCS_SSD@bcbstx.com

BlueCross BlueShield of New Mexico

Section A: Confidential Communication Request or Modification/ Termination of Existing Confidential Communication Request

Please choose one of the following:

- ☐ Initial Request – This is your first Confidential Communication Request. (Complete entire form.)
- ☐ Modify a Previous Request – This form is modifying (i.e., adding an alternative address) a previously approved Confidential Communication Request. (Complete entire form.)

Section B: Member Information

Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____

Email Address (if available): _____ Date of Birth: _____

Social Security Number: _____

Member ID Number: _____

Section C: Please complete the section below with regards to your Confidential Communication Request:

Alternative Location Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____

Email Address (if available): _____

Payment information will be sent to alternate address until further notice.

_____

_____

_____

BlueCross BlueShield of New Mexico

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

1. The request only applies to your current coverage. If any of the information about your coverage changes, you must submit a new Confidential Communication Request. Changes may include a new Group or Subscriber number or benefit coverage changes.
2. The request will expire eighteen (18) months after coverage.
3. BCBSNM 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 Member, parent of minor child, or the Member's authorized representative.

I request that BCBSNM release my PHI using the means in Section C above. I understand that BCBSNM does not have to agree to my request. I understand I will receive a written decision 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**

Section E: If Section D is signed by an authorized representative, please complete the information below:

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.

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: _____

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 **https://www.hhs.gov/ocr/complaints/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' hódíílnih 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 یسراف وگنفگ یم دینک، تلایهست ینابز هب تروص ناگیار یارب امش مهارف یم دشاب. اب 1-855-710-6984 (TTY: 711) سامت دیریگب.

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