Confidential Communications Request

Mail to: Western Health Advantage, Attn: Member Services
2349 Gateway Oaks Drive, Suite 100, Sacramento, CA 95833
Fax to: 916.568.0126
Email to: memberservices@westernhealth.com
Include in Subject Line: Confidential Communications Request
Questions? 916.563.2250, 888.563.2250 toll-free or 888.877.5378 for TDD/TTY

Member Name (First, Last) _____

Date of Birth _____ WHA ID _____

Street Address _____ City, State, Zip _____

Phone Number_____

This request is: Check [✓] one NEW | MODIFIED
TO REVOKE an existing request effective (indicate date) _____Skip to Revocation

I am contacting you to request that my medical information be delivered by alternate means or to an alternate address below for the following reason(s): Check [✓] one or both

[ ] **My medical information relates to sensitive services.** ("Sensitive services" include sexual and reproductive health care, mental health, sexual assault counseling and care and treatment for alcohol and drug use.)

[ ] **Disclosure of my medical information could endanger me or subject me to harassment or abuse.** (You will never be asked to explain this.)

Alternative Means or Alternate address: WHA will send your medical information to one of the options below. Check [✓] the option(s) that are safe for you to receive information. If you check more than one option, indicate a "1" next to your first choice, "2" next to your second choice and so on. Include email or mailing address in the space provided.

option # _____ | EMAIL to: _____

option # _____ | MAIL to: Street Address _____

City, State, Zip _____

option # _____ | OTHER: _____

I understand and agree to the following:

- WHA will send all of my medical information to this address.
- I must notify WHA if I wish to change this information. This request is valid until I submit a revocation or a new request.
- This form will affect only communications from Western Health Advantage. If I also wish my employer, physician or anyone outside of Western Health Advantage to make this change, you must contact them directly. (Call WHA Member Services for contact information for these entities).
- This request will only apply to my current membership ID number. If my membership ID number changes, I must submit a new Confidential Communications Request.
- This request will expire eighteen (18) months after my benefits coverage has terminated.

Revocation: If I have indicated this is a **revocation** above, revoke my confidential communications request and use the following address for all of my medical information.

Street Address _____ City, State, Zip _____

_____

MEMBER NAME (PRINT) MEMBER SIGNATURE DATE

WHA Internal Use Only Date Request Received _____

Member Identification verified (list documents checked/reviewed _____

If request was received by phone: Date_____Time _____ Date Request Fulfilled _____

_____

MANAGER OR SUPERVISOR NAME (PRINT) MANAGER OR SUPERVISOR SIGNATURE DATE