REQUEST FOR CONFIDENTIAL COMMUNICATIONS

This form is for use by a West Region beneficiary or the beneficiary's authorized representative to request that TriWest Healthcare Alliance (TriWest) use alternative means or an alternative address for the communication of the beneficiary's protected health information (PHI) if sending communications to the address of record could endanger the beneficiary.

Section A: Individual Requesting Confidential Communications

Name:			
Address:			
Telephone:		Email:	
Social Security Number:			

TO THE BENEFICIARY: Please read the following and complete the information requested.

You have the right to request that TriWest communicate with you all, or part of, your PHI in confidence by alternative means or to an alternative location that you specify.

TriWest will accommodate your request if:

a) it is reasonable,
b) you represent that failure to communicate your PHI in confidence by the alternative means, or to the alternative location you specify, could endanger you,
c) you provide TriWest with a reasonable alternative means or location for communicating with you, and
d) you provide a satisfactory explanation of how any applicable enrollment premium, co-payments, cost share and other payments will be handled under the alternative means or location you request.

To exercise your right, please complete Section B.

Section B: Type of Confidential Communications Being Requested

Please describe the PHI you want to include in the specified confidential communications.

Section B: Type of Confidential Communications Being Requested (continued)

I request TriWest use the following alternative means of communicating with me about my PHI. (Please provide a complete description and full information about the alternative means you want TriWest to use.)

I request that TriWest communicate with me about my PHI at the following alternative location. (Please provide full information about the alternative location.)
Section C: Requesting Individual's Signature
I attest that failure to communicate my PHI by the alternative means or to the alternative address could endanger the individual named in Section A.
SIGNATURE OF BENEFICIARY OR AUTHORIZED REPRESENTATIVE (below)
Date:
If this request is by an authorized representative on behalf of the beneficiary, complete the following:
Personal Representative's Name:
Relationship to Beneficiary:

Reminder: If you move or otherwise need to change the alternative means of communication or alternative address, you need to complete this form with the new information.

Please submit the completed and signed request to:
TriWest Healthcare Alliance
Attn: HIPAA Privacy Official
P.O. Box 2585
Virginia Beach, VA 23450
Fax: 877-875-1340