# Icon Description automatically generated

# CALIFORNIA CONFIDENTIAL / ALTERNATE COMMUNICATION REQUEST FORM

Date

Individual/Member Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Individual/Member Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Individual/Member ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request that Carelon Behavioral Health send my confidential protected health information (PHI) to an alternate address and/or use an alternate method to contact.

###### *Alternate Contact Information*

* I request that my PHI be mailed to:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_

* I request that my PHI be emailed to:

E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Note:** Information that is sent out automatically by our systems cannot be emailed and will be sent to the mailing address provided

* I request that calls are made to:

Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request that Carelon Behavioral Health send my confidential protected health information (PHI) to the main address on record, revoking the prior request to send my PHI to an alternate address.

###### *Revoke the following contact information:*

* Contact and Mailing Address:

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_ Zip Code \_\_\_\_\_\_\_\_\_\_\_\_

* E-mail Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Beacon may contact me, as needed, at this telephone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please be aware:*

* Reimbursement of behavioral healthcare services is issued to the subscriber (when the dependent is under the age of twelve (12)) or provider of services only. All requests to change this **must** include an explanation of why payment should be made to someone other than the subscriber.
* All claims submitted that require reimbursement to someone other than the subscriber (when the dependent is under the age of twelve (12)) **must** be accompanied with proof of payment (i.e., cancelled check or the provider’s receipt of payment with the payer identified).

## I understand that Beacon will use the above alternate communication information until I change this request. I understand that I may change or revoke this request at anytime by completing another Confidential/Alternative Request Form.

## If you are requesting a confidential communication change on behalf of someone other than yourself, please enclose proof of your authority to do so (i.e., guardianship order, custody order, court order).

Signature of Requestor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name of Requestor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mail or e-mail completed form and supporting documentation, if applicable to:

Beacon Health Options

Clinical Operations

PO Box 6065

Cypress, CA 90630-0065

E-mail: [CAAlternateCommunicationRequests@carelon.com](mailto:CAAlternateCommunicationRequests@carelon.com)

##### Definitions

* **Individual/member:** the person who is the subject of the protected health information
* **Legally Authorized Representative**: someone who has the legal authority to act on an individual’s behalf in order to make decisions about that person’s health care. Parents may be personal representatives for minors, except those minors who have been given the legal freedom to act on their own. Personal representatives may include guardians, conservators and other persons who have been given legal responsibility for another individual. Federal law, state law and the specific terms of the appointment determine the authority granted to the personal representative.
* **Member identification number:** the number assigned to an individual by a health plan; sometimes it is the individual’s social security number