Request for Confidential Delivery of Protected Health Information and/or Confidential Communication of Medical Information Involving Sensitive Services:

This form is intended to be used to request that Community Health Plan of Imperial Valley (CHPIV) delivers your Protected Health Information ("PHI") to a confidential mailing address, email address, or telephone number. The requested information on this form may also be submitted in a written format to CHPIV at the mailing address, email address, or fax number at the bottom of the form.

Your request will be applicable only when PHI is exchanged by CHPIV and its contracted providers. If reasonable accommodation is not available this may result in a denied request. If your request is approved and a change in address later occurs, Member identification number changes, you will be required to resubmit a new request for confidential delivery of protected health information to CHPIV. You may rescind your request for confidential delivery of protected health information by submitting a written request to CHPIV at the mailing address, email address, or fax number at the bottom of the form.

This form may also be used to request confidential communication of medical information involving Sensitive Services. "Sensitive Services" include all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, transgender health, including gender affirming care, and intimate partner violence, and included services. Communications (written, verbal, or electronic communications) regarding your receipt of sensitive services shall include:

- Bills and attempts to collect payment.
- A notice of adverse benefits determinations.
- An explanation of benefits notice.
- A plan's request for additional information regarding a claim.
- A notice of a contested claim.
- The name and address of a provider, description of services provided, and other information related to a visit.
- Any written, oral, or electronic communication from a plan that contains protected health information.

Individual requesting Confidential Communication of PHI/Confidential Communication of Medical Information Involving Sensitive Services:

Name: _____

Subscriber ID number: _____

Phone number: _____

Date of birth: _____

Email address: _____

For Request for Confidential Delivery of Protected Health Information:

☐ **I request that Community Health Plan of Imperial Valley communicate all of my PHI to me through the following:**

- ☐ Confidential Mailing Address: _____
- ☐ Confidential Phone Number: _____
- ☐ Confidential Email Address: _____

Signature of Individual, parent of minor child, or personal representative:

Signature: _____ Date: _____

Printed Name: _____

If the signature on this form is not of the Individual or the parent of a minor, such as a personal/legal representative or guardian, you will be required to submit documentation exhibiting your legal authority to represent the Individual in relation to their healthcare/PHI. The documentation may include:

1. HIPAA Authorization;
2. Health Care Power of Attorney;
3. Guardianship papers; or
4. Other valid documentation establishing your legal authority to act on behalf of the Individual.

Representative's name (print): _____

Relationship to Member: _____

Type of documentation submitted: _____

Representative's Signature: _____ Date: _____

For Confidential Communication of Medical Information Involving Sensitive Services:

☐ **I request that Community Health Plan of Imperial Valley communicate medical information regarding Sensitive Services through the following:**

- ☐ Confidential Mailing Address: _____
- ☐ Confidential Phone Number: _____
- ☐ Confidential Email Address: _____

In the absence of a designated alternative mailing address, email address, or telephone number, if you request to receive confidential communication of medical information regarding

Sensitive Services, Community Health Plan of Imperial Valley will communicate such medical information to your address and/or telephone number on file with Community Health Plan of Imperial Valley in your name.

If you request to receive confidential communication of medical information regarding Sensitive Services:

- Community Health Plan of Imperial Valley shall not disclose medical information related to sensitive health care services provided to you to the primary subscriber or any plan enrollees other than you, absent your express authorization to do so;
- Community Health Plan of Imperial Valley shall permit and accommodate requests for confidential communication in the form and format requested, if readily producible in the requested form and format, or at alternative locations;
- Community Health Plan of Imperial Valley shall implement confidential communications requests within 7 calendar days of receipt of an electronic or telephonic request or within 14 calendar days of receipt by first-class mail.
- Community Health Plan of Imperial Valley shall acknowledge receipt of confidential communications requests and advise you of the status of implementation of your request if you contact us; and
  Your request will remain valid until you submit a revocation of request or submit a new request for confidential communication of medical information regarding Sensitive Services.

Signature of protected Individual:

Signature: _____ Date: _____

Printed Name: _____

You may return this completed and signed form via one of these options:

Mail: Community Health Plan of Imperial Valley
C/O Member Services
Department P.O Box 174
Imperial, CA 92251

Email: chpivmemberservices@chgsd.com

Fax: (760) 457-3007