Request for Alternate Means of Confidential Communications

AmeriHealth Caritas VIP Care

Use this form so that communications of your protected health information (PHI) are carried out by alternative means or at an alternate location. We will not disclose the PHI of our members to any individuals who may contact us on your behalf unless written authorization has been submitted or the disclosure is otherwise allowable under law.

Please complete the following with the information we currently have on file for you:

Name:			Phone:
Address:			
City:	State:	ZIP code:	Member ID number:

Please carefully read the following: At AmeriHealth Caritas VIP Care (HMO-SNP), we mail communications containing your PHI, such as an Explanation of Benefits, to the subscriber (the person whose name appears on your ID card). These communications are sent to the address listed in our membership records for you. We also rely upon telephone information in your membership records when we contact you by phone.

If you believe the above methods of communication could endanger you, you have the right to request that we:

- Use a reasonable alternate means for communicating your PHI.
- Send your PHI to an alternate address.
- Contact you at an alternate phone number.

We will not accommodate requests for communications to alternate addresses made solely for reasons of convenience.

Please sign and date: I attest that I have read the above statement and that I require communication about my PHI by an alternate means or at an alternate address indicated below because I believe any other method of communication could endanger me.

Signature:	Date:

Alternate contact information (please provide full information regarding the alternate means, address, phone number, etc., that you want us to use):

Personal representative: If you are not the member, please sign and date below. Check the box that describes your relationship to the member. **If you are not the parent or legal guardian, please attach proof of your relationship to the member (e.g., power of attorney, personal representative documentation, etc.).**

Print name of personal representative:
Signature of personal representative and date:

☐ Parent or legal guardian ☐ Power of attorney ☐ Executor ☐ Other:_____

Please return this form to: AmeriHealth Caritas VIP Care
Medicare Compliance
3875 West Chester Pike
Newtown Square, PA 19073