# REQUEST FOR CONFIDENTIAL COMMUNICATION

This form will allow me, as a Zing Health member to request to receive communications of Protected Health Information (PHI) about me by alternative means or at alternative locations.

If a request is made for an alternate location, I understand correspondence will continue to be addressed to me but will be mailed to the address I provide below. I understand all member correspondence to me will be mailed to this alternative address whether or not it contains any confidential information about me. I understand that his request may be denied if it cannot reasonable be accommodated.

Note: If your request is granted, it will affect only written and oral communications by Zing Health. If you also wish another health plan, physician or anyone outside of Zing Health to make this change, you must obtain their agreement separately.

**If you need assistance completing the form, please contact Customer Services at 1-866-946-4458 (TTY: 711)**

| Section 1. Member Information | | | |
|---|---|---|---|
| Member Last Name: | Member First Name | | Member Middle Name: |
| Date of Birth: | Member ID#: | | |
| Street Address: | | | |
| City: | State: | Zip Code: | Phone Number: |

**REQUEST:** I request to receive communications of my PHI from Zing Health:

☐ By alternate means or location (please describe and provide address): _____

_____

**PLEASE NOTE**

- Communications containing your PHI will to be sent to the address you have provided on this form.
- If an alternate address is approved, it may be shown on correspondence about you that Zing Health sends to others, such as your provider.
- If the information on this form is not complete, Zing Health will return the form to you, and this request may not be considered until Zing Health receives complete information.
- If your Member ID or date of birth changes, a new form must be submitted.
- You may change or revoke this request by sending a written request to Zing Health at the address below.

**Please complete the other side.**

## Signature

I have read and understand the above information.

_____ _____

Member or Representative's Signature Date

_____ _____

Printed Name of Representative (if applicable) Relationship to Member

IF THE PERSON SIGNING THE FORM IS NOT THE MEMBER WHO IS THE SUBJECT OF THE REQUESTED INFORMATION, WRITTEN EVIDENCE OF THE PERSON'S AUTHORITY TO AMEND THE REQUESTED INFORMATION (INCLUDING PROTECTED HEALTH INFORMATION) MUST BE PROVIDED. THAT EVIDENCE MAY BE IN THE FORM OF A WRITTEN AUTHORIZATION FROM THE MEMBER OR A DESIGNATION FROM A COURT OF COMPETENT JURISDICTION.

**PLEASE MAKE A COPY OF THIS FORM FOR YOUR RECORDS**.

Mail the completed form to:

Zing Health
Privacy Officer
225 West Washington Street, Suite 450
Chicago, IL. 60606

## For Office Use Only

Date Received: _____ Process Date: _____

☐ Accepted ☐ Denied: _____

Date Notified: _____ Notified By: _____ Title: _____