Sentara Health Plans

REQUEST FOR PHI TO BE COMMUNICATED BY ALTERNATE MEANS OR LOCATION

Use this form to request an alternate confidential means of receiving communications that includes the member's protected health information (PHI)

Member Name: _____

Date of Birth: _____ / _____ / _____ Member ID Number: _____

I _____ request that Sentara Health Plans*:*

☐ Send my protected health information to an alternative address. Mail to:

_____ _____ _____
First Name MI Last Name

_____ _____
Street Address Apartment #, if any

_____ _____ _____
City State Zip Code

☐ Use an alternate method of communicating my protected health information. Method of communication including how I can be reached:

_____

_____

☐ Mark this box if all or part of the PHI could endanger the individual if not communicated by the requested alternative means or at the alternative location

I understand that I may revoke or change this request at any time by writing to **Sentara Health Plans;** however, **Sentara Health Plans** will use this authorization until it receives written notice. I understand that I am still responsible for my part of the payment for services provided. Payment notice is to be sent to my alternate location, to the location below, or by the method below:

Location or method of communication of payment notice if different than above:

_____

_____

Mail or email this completed request form to: Sentara Health Plans Compliance
PO Box 66189
Virginia Beach, VA 23466
shpprivacy@sentara.com

Privacy Statement: Please be aware that email and text communication can be intercepted in transmission or misdirected.

_____ _____
Signature of Member Date

_____ _____
Signature of Personal/Authorized Representative, Parent, or Guardian Date