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BULLETIN 14-18

To: **All Interested Parties Including Insurers, Non-Profit Health Service Plans, Health Maintenance Organizations, and Dental Plan Organizations and any Other Person that Provides Health Benefit Plans Subject to Regulation by the State ("Carriers")**

Re: **Senate Bill 790- Draft Proposed Standardized Form -Request for Confidential Communications**

Date: **June 20, 2014**

The purpose of this Bulletin is to solicit comments from carriers and interested parties regarding the proposed standardized form that consumers will use to request confidential communications from carriers. The authority for the proposed standardized form can be found in Senate Bill 790, Chapter 72, Acts of 2014. A copy of the draft proposed standardized form is attached to this Bulletin. A carrier that requires an enrollee to make a request for confidential communications in writing is required to accept the standardized form. Senate Bill 790 also permits a carrier to accept any other form of written request from an enrollee for confidential communications under the Health Insurance Portability and Accountability Act privacy rule.

Written comments will be accepted for 14 days from the date of the Bulletin's issuance. All comments should be address to Nancy Egan, Director of Government Relations, at nancy.egan@maryland.gov. If there are any questions, Ms. Egan can be reached at 410-468-2488.

Signature on original

Brenda A. Wilson
Associate Commissioner
Life and Health

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

FORM

If you are covered under a health insurance policy, and you could be endangered by the disclosure of your protected health information through a health insurer's communication to the policyholder or certificate holder, this form allows you to request that communications of your protected health information from your insurer be sent by alternative means or to an alternative location.

Policyholders (or certificate holders for group contracts) receive information about the health care services received by family members and dependents covered under their policy. So, if your spouse, partner, or parent is the policyholder or certificate holder, this information may be sent to them. Examples of the most common information sent by insurers are "Explanation of Benefits" forms, and claim denial letters.

Before submitting this form to your insurer, you may wish to contact your insurer to determine if it permits a request to be taken over the phone or by e-mail. If the insurer requires a written request, please complete this form and submit it to your insurer.

NOTE: If your insurer grants your request, it will affect only written and oral communications with that insurer. After you submit this form, check back with your insurer to make sure your request has been processed and approved. Until that time, the insurer may continue to send information to the policyholder or certificate holder. You will need to contact the employer, other insurers, and each of your health care providers, separately to request that they not send any confidential communications to the policyholder or certificate holder.

Verification- (Please print)

The following information is needed to identify you:

Insurance Company Name: _____

Your Name: _____

Last Name **First Name** **Middle Name**

Date of Birth: _____

Name of the Policyholder or Certificate Holder: _____

_____

Address of Policyholder or Certificate Holder: _____

_____

Phone number where you would like the insurance company to reach you if it needs to contact you to process your request: _____

Additional information to identify you to the insurance company:

Your member ID card number (if available): _____

Group or Account # on ID card (if available): _____

REQUEST:

1. I request to receive communications of my protected health information from my insurance company by alternative means* (example: fax, e-mail, or telephone) or alternative address as follows (Please describe in detail your proposed alternative means or alternative address):

_____

_____

_____

2. Reason why the alternative means or alternative location is necessary (Choose one)**:**

□ **I could be endangered if all or part of my protected health information is disclosed to the policyholder or certificate holder.**

□ **Other (**Please provide reason**):**_____

_____

_____

_____

Signature **Date**

***Requests by some alternative means may not be secure and may be intercepted by others. Your carrier is not responsible if such intercepts occur.**