

Member Name: _____

Planholder SSN: _____ Date: _____

Member Relationship to Planholder _____



REQUEST FOR ALTERNATIVE COMMUNICATIONS REGARDING YOUR PROTECTED HEALTH INFORMATION

I. Your Protected Health Information

The Kentucky Employees' Health Plan ("KEHP") collects and maintains protected health information ("PHI") that includes personal identifiers, enrollment, eligibility, and dependent and qualifying event information. KEHP utilizes a third-party claims administrator and a pharmacy benefits manager, referred to as "Business Associates," to carry out certain functions for KEHP. Because of their administrative responsibilities, these Business Associates create, receive, maintain, and transmit PHI on behalf of KEHP. Like KEHP, the Business Associates are responsible for ensuring the protection of your health information.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), KEHP and its Business Associates may use and disclose your PHI for treatment, payment, or health care operations including, but not limited to, claims processing, billing, case management, provider credentialing, and utilization review. Other uses and disclosures permitted or required by HIPAA are outlined in KEHP's Notice of Privacy Practices.

II. Your Rights

You have the right to request to receive communications of PHI from KEHP by alternative means or at alternative locations (i.e. by e-mail, at home, at work). KEHP will accommodate reasonable requests to receive communications by alternative means or at alternative locations provided you clearly state, in writing:

- that the disclosure of all or part of your PHI could endanger you;
- how payment, if any, will be handled; and
- an alternate address or other method of contact.

III. Request for Alternative Communications

(a) Specify the types of communications regarding your PHI that are subject to your request:

Member Name: _____

Planholder SSN: _____ Date: _____

Member Relationship to Planholder _____

(b) Specify the types of communication methods that are subject to your request. *(Check all that apply)*

E-mail Mailing Address Telephone Other _____

(c) Provide the alternative contact information:

➤ E-mail address: _____

➤ Mailing address:
Street address/P.O. Box #: _____

City, State, and Zip: _____

➤ Telephone #: _____

If no alternative contact information is provided, KEHP will use contact information on file.

(d) Could disclosure of all or part of the information to which the request pertains endanger you? *(Check one)*

Yes No

IV. Signature of Member or Member's Personal Representative *(Form MUST be completed before signing.)*

By signing below, you understand:

- You may revoke this authorization at any time provided the revocation is in writing. The revocation will not apply to the extent that KEHP has taken action in reliance on the authorization. A written revocation, specifying the authorization intended to be revoked, shall be submitted to the Privacy Officer at the address below.
- You are not required to sign this authorization as a condition to treatment, payment, enrollment, or eligibility for benefits under KEHP. This authorization is voluntary, and you may refuse to sign it.
- Information disclosed pursuant to this authorization is subject to possible re-disclosure by the recipient and will no longer be protected.

Printed Name of Member

Printed Name of Member's Personal Representative
(If Applicable)

Signature of Member or
Member's Personal Representative

If a Personal Representative – Describe Relationship
to Member. Include authority/documentation proving
status as a Personal Representative.

Date: _____

Member Name: _____

Planholder SSN: _____ Date: _____

Member Relationship to Planholder _____

Remit Form To: William H. Adams II, Privacy Officer
Personnel Cabinet
501 High Street, 4th Floor
Frankfort, KY 40601
Fax: (502) 564-7603
Will.Adams@ky.gov

V. KEHP Response to Your Request for Alternative Communications

KEHP will accommodate reasonable requests to receive communications by alternative means or at alternative locations. KEHP:

- Has changed your contact information and will contact you in the manner specified by your request.
- Has not changed your contact information in accordance with your request as you have not:
 - Specified how payment will be handled (if applicable);
 - Provided a valid alternative address or other contact information; or
 - Affirmatively stated that disclosure of all or part of the information to which the request pertains could endanger you.

Signature of KEHP Privacy Officer

Date Received: _____

Date Copy Mailed to Member: _____