



REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Purpose: This form is for use by a TRICARE beneficiary or the beneficiary's authorized representative to request that TriWest use an alternative means of, or an alternative location for, the confidential communication of the beneficiary's protected health information.

Section A: Individual Requesting Confidential Communications

Name:							
Address:							
Telephone:				E-mail:			
Social Security Numbers	Sponsor:				Beneficiary:		

TO THE BENEFICIARY: Please read the following and complete the information requested.

You have the right to request that TriWest Healthcare Alliance communicate with you all or part of your protected health information in confidence by alternative means, or to an alternative location that you specify, in order to avoid endangerment to yourself.

TriWest will accommodate your request if (a) it is reasonable, (b) you represent that failure to communicate your protected health information in confidence by the alternative means, or to the alternative location you specify, could endanger you, (c) you provide TriWest with a reasonable alternative means or location for communicating with you, and (d) you provide a satisfactory explanation of how any applicable enrollment premium, co-payments, cost share and other payments will be handled under the alternative means or location you request. TriWest will not investigate the validity of your claim of endangerment.

To exercise your right, please complete Section B.

Section B: Type of Confidential Communications Being Requested

Could failure by TriWest to communicate your protected health information in confidence by the requested alternative means, or to the requested alternative location you specify, endanger you? Yes No

Please describe the protected health information you want to include in the specified confidential communications.

Please explain how any communications pertaining to enrollment premiums, co-payments, cost shares and other payments will be handled.



Section B: Type of Confidential Communications Being Requested (continued)	
	I request that TriWest use the following alternative means of communicating with me about my protected health information.
	Please provide a complete description and full information about the alternative means you want TriWest to use.
	I request that TriWest communicate with me about my protected health information at the following alternative location.
	Please provide full information about the alternative location.
Section C: Requesting Individual's Signature	
I attest that failure to communicate about my protected health information by the alternative means or to the alternative location I have requested could endanger me.	
BENEFICIARY'S SIGNATURE	
	Date:
If this request is by a personal representative on behalf of the beneficiary, complete the following:	
Personal Representative's Name:	
Relationship to Beneficiary:	
YOU ARE ENTITLED TO A COPY OF THIS REQUEST	

Please submit the completed and signed request to TriWest Healthcare Alliance; Attn: HIPAA Privacy Official; P.O. Box 42049; Phoenix, AZ 85080-2049