REQUEST FOR ALTERNATE MEANS OF CONFIDENTIAL COMMUNICATIONS

Use this form if you want to receive mail or phone calls from Neighborhood at a different address because you have concerns about your safety.

INSTRUCTIONS

Section A:	**Fill in your name, address, phone number and Neighborhood ID number.**
Section B:	**If you are a member's Personal Representative, please add your name here and attach the proper document** (for example, a signed Power of Attorney).
Section C:	**Fill in the address and/or phone number where you would like Neighborhood to contact you.**
Section D:	**You or your Personal Representative MUST sign this document.**
Please return this form to:	**Neighborhood Health Plan of Rhode Island** **Attn: Compliance Department** **910 Douglas Pike** **Smithfield, RI 02917**

If you need help with this form please contact
Neighborhood Member Services at 1-800-963-1001 (TTY 711).

Neighborhood Health Plan of Rhode Island's INTEGRITY for Duals (HMO D-SNP) and Dual CONNECT (HMO D-SNP) are health plans that contract with Medicare and the Rhode Island Medicaid Program. Enrollment in Neighborhood Health Plan of Rhode Island's INTEGRITY for Duals or Dual CONNECT plan depends on contract renewal.

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Neighborhood Health Plan OF RHODE ISLAND™

REQUEST FOR ALTERNATE MEANS OF CONFIDENTIAL COMMUNICATIONS

SECTION A: MEMBER INFORMATION

Please fill out:

NAME		DAYTIME PHONE NUMBER	
ADDRESS			
CITY	STATE	ZIP	MEMBER ID#

NOTE: Neighborhood Health Plan of Rhode Island might send you mail that contains your protected health information or call you at the address and phone number listed in our records. If you believe this could put you at risk, you have the right to ask that we use another way to contact you (Neighborhood policy #000054). We will not do this only for reasons of convenience.

SECTION B: PERSONAL REPRESENTATIVE

*Only complete this section if you are not the member. Please print your name below and then check the box that describes your relationship to the member. **Please attach proof of your relationship to the member (ex. power of attorney, guardianship, etc.).**

Print name of personal representative: _____

- ☐ **Legal guardian**: Attach guardianship documentation, which must have a court's stamp and signature.
- ☐ **Power of attorney**: Attach power of attorney (must include authorization of the release of health care information)
- ☐ **Executor**: Attach letter of appointment of executorship, which must have a court's stamp and signature.

SECTION C: NEW CONTACT INFORMATION

Please give us the address, phone number, etc. you want us to use:

ADDRESS		
CITY	STATE	ZIP
DAYTIME PHONE NUMBER	EMAIL ADDRESS	

SECTION D: SIGNATURE

Please sign and date:

I have read the above statement and believe that I need my health information to be sent to me at another address and/or phone number because I believe other methods could endanger me.

_____ _____

MEMBER or PERSONAL REPRESENTATIVE SIGNATURE *DATE*