Neighborhood Health Plan OF RHODE ISLAND™

# 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**<br>**Attn: Compliance Department**<br>**910 Douglas Pike**<br>**Smithfield, RI 02917** |

Neighborhood Health Plan of Rhode Island complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish: ATENCIÓN: Si habla Español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-401-459-6019 (TTY 711).

Portuguese: ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 1-401-459-6019 (TTY 711).

If you need help with this form please call Neighborhood Member Services at 1-800-459-6019 (TTY 711).

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## 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. We will not do this only for reasons of convenience.

## SECTION B: PERSONAL REPRESENTATIVE

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:*

_____

_____

_____

_____

## 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/PERSONAL REPRESENTATIVE SIGNATURE* *DATE*