Horizon NJ Health

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Read instructions on Page 2 before completing this form. **ALL FIELDS MUST BE COMPLETED**. A separate form is required for each member on the policy, as applicable. Please print all information legibly, except where signature is required.

To request a confidential communications, please complete the information below, sign in the space provided and return to: Horizon NJ Health, Attn: HIPAA Team, 1700 American Blvd. Pennington, NJ 08543 or via fax at **1-609-538-1574**.

SECTION A - MEMBER INFORMATION

1. Member's name: ______________________ 2. Date of Birth: ______________

3. Subscriber's Name: ______________________

4. Horizon NJ Health Member ID#: ______________________

5. Address: ______________________

SECTION B - REASON FOR REQUEST

Provide the reason(s) for your request. Your answer should be specific and detailed.

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SECTION C - ALTERNATE CONTACT INFORMATION

Postal Address: ______________________

City: ______________________State: __________ Zip: ______________

*If an alternate address is not provided, Horizon NJ Health will keep all of your mail and you will have to contact the Privacy Office to retrieve it.

Telephone #:______________________ Email address: ______________________

Password for oral communications with Horizon NJ Health:______________________

(Your password must be 4 to 10 characters in length; can use a combination of letters and numbers. Assign a password that only you know.)

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I, ______________________, request communication of my private information by Horizon NJ Health and its business associates, be sent to an alternative location or as otherwise agreed above. I understand this request applies only to communications from Horizon NJ Health to me. I also understand this will be in effect until I submit a written request to terminate or change it, and Horizon NJ Health processes such written request.

Signature of Member / Requestor* ______________________Date:______________

Printed Name ______________________

*Circle whether member or other requestor. If the requestor is other than the member, requestor must sign form and attach documentation showing authorization to act on behalf of member.

Independent licensee of the Blue Cross and Blue Shield Association

Horizon NJ Health

INSTRUCTIONS: REQUEST FOR CONFIDENTIAL COMMUNICATIONS

General Instructions: All fields are required unless specified otherwise.

This form should be completed when a member wishes to establish an alternate means of communication with Horizon NJ Health. However, the request must first meet the criteria established by the HIPAA Regulations to be considered a valid Confidential Communications request. If Section B-Reason for Request field does not meet this standard, it will be denied and the member will be advised to complete the appropriate HIPAA Form.

NOTE: A separate form and documentation is required for each member on the coverage, as applicable.

Section A. Member Information

This section requests information related to the member for which confidential communications with Horizon NJ Health are requested. In the subscriber field, write the name of the policy holder. The policy holder is the individual who holds the insurance policy with Horizon NJ Health.

Section B. Reason for Request

Member or requestor should provide as much information as possible for Horizon NJ Health to be able to determine if the request is reasonable and meets the criteria of a valid Confidential Communications request as defined by the HIPAA Regulations. If the form does not meet the criteria, the request will be denied and the member will be advised of the appropriate form to complete.

Section C. Alternate Contact Information

The information given will provide Horizon NJ Health an alternate means of communications with the member. All correspondence intended for the member will be directed to the alternate address on the form. The correspondence will be redirected to the alternate address provided; however, correspondence will continue to be addressed to the subscriber.

If no address is provided or cannot be provided, correspondence will be received by Horizon BCBSNJ's Privacy Office. The member must contact the Privacy Office to retrieve it. You may contact the Privacy Office by mail: Privacy Office PP-16C Horizon BCBSNJ, PO Box 420, Newark, NJ 07101-9968; or by phone **1-973-466-5781**.

Members are asked to provide a password to better enable Horizon NJ Health to control access to their private information. This password will be required from the caller during the verification process.

Mail this form to:

Horizon NJ Health
Attn: HIPAA Team
1700 American Blvd.
Pennington, NJ 08543

or Fax to:

1-609-538-1574

Notice of Nondiscrimination

Horizon NJ Health complies with applicable Federal civil rights laws and does not discriminate against nor does it exclude people or treat them differently on the basis of race, color, gender, national origin, age, disability, pregnancy, gender identity, sex, sexual orientation or health status in the administration of the plan, including enrollment and benefit determinations.

Horizon NJ Health provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and information written in other languages.

Contacting Member Services
Please call Member Services at **1-800-682-9090** (TTY **711**) or the phone number on the back of your member ID card, if you need the free aids and services noted above and for all other Member Services issues, including:

- Claim, benefits or enrollment inquiries
- Lost/stolen ID cards
- Address changes
- Any other inquiry related to your benefits or health plan

Filing a Section 1557 Grievance
If you believe that Horizon NJ Health has failed to provide the free communication aids and services or discriminated on the basis of race, color, gender, national origin, age, or disability, you can file a discrimination complaint also known as a Section 1557 Grievance. Horizon NJ Health's Civil Rights Coordinator can be reached by calling the Member Services number on the back of your member ID card or by writing to the following address:

Horizon NJ Health – Civil Rights Coordinator
PO Box 10194
Newark, NJ 07101

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights (OCR), electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

Office for Civil Rights Headquarters
U.S. Department of Health and Human Services 200 Independence Avenue, SW
Room 509F, HHH Building Washington, D.C. 20201
1-800-368-1019 or 1-800-537-7697 (TDD)

OCR Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html.**

Para ayuda en español, llame a **1-800-682-9090** (TTY **711**).

Multi-Language Insert
Multi-language Interpreter Services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call 1-800-682-9090 (TTY 711). This document is also available in other languages, as well as other formats, such as large print and Braille.

ATENCION: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüistica. Llame al **1-800-682-9090** (**TTY 711**).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-682-9090** (TTY **711**).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-800-682-9090 (TTY **711**) 번으로 전화해 주십시오.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis.
Ligue para **1-800-682-9090** (TTY **711**).

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો
1-800-682-9090 (TTY **711**).

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer **1-800-682-9090** (TTY **711**).

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti.
Chiamare il numero **1-800-682-9090** (TTY **711**).

ملا :حوظةللغوية تترفاو لابكلمناجـ. تـنك إذ ةقم ترتصل بارقم هاتفـتا ركذا حدثللمإن خدف ، ،غةات المعداسد **1-800-682-9090**
(كبلاو صمـلام **711**)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-682-9090** (TTY **711**).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.
Звоните **1-800-682-9090** (телетайп **711**).

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou.
Rele **1-800-682-9090** (TTY **711**).

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
1-800-682-9090 (TTY **711**) पर कॉल करें।

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-682-9090** (TTY **711**).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-800-682-9090** (ATS **711**).

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں
1-800-682-9090 (TTY **711**).