GEHA

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REQUEST FOR CONFIDENTIAL COMMUNICATION

This form is for subscribers and members covered by the GEHA Health, GEHA Connection Dental Federal, CONNECTION Dental *Plus* plans and/or Connection Vision Plan. Please place a check mark in front of each plan you want this Confidential Communication request to be applied.

NOTE: At least one line MUST be checked for this form to be valid.

- ☐ GEHA Health Plan (includes Connection Vision Plan)
- ☐ GEHA Connection Dental Federal Plan (includes Connection Vision Plan)
- ☐ CONNECTION Dental *Plus* Plan (includes Connection Vision Plan)
- ☐ CONNECTION Vision Plan only

NOTE: ALL AREAS OF THIS FORM MUST BE COMPLETED IN FULL.

You have the right to request confidential communications in regard to your protected health information if disclosure of all or part of that information to a person could endanger you. If disclosure would not endanger you, you have the right to request a "Restriction". (Note: The "Request for Restriction" form may be printed from the GEHA website at www.geha.com, or you may contact Customer Service at (800) 821-6136 to request the form by mail.)

Subscriber/Member Information:

Subscriber Name: _____

Address: _____

Subscriber ID Number: _____ **Telephone Number:** _____

Patient Name: _____ **Date of Birth:** _____

I hereby state that disclosure of all or part of my protected health information could endanger me and am requesting confidential communications due to such potential endangerment. Please send correspondence to the following address and direct telephone calls to the following number:

Name: _____

C/O (In Care Of): _____

Address: _____

Telephone Number: _____

By signing this form, I am giving notice that disclosure of information could endanger me. I further **understand that this will require up to fifteen (15) working days from the date received by GEHA to execute this request and forward to GEHA's business associates, who partner with us to assist in providing services in areas such as pharmacy, radiology, precertification, vision, etc.** (as outlined in GEHA's Notice of Privacy Practices available at www.geha.com). I understand that GEHA is only required to accept reasonable requests for Confidential Communications when there is endangerment and all other reasons require submission of a request for "restrictions" on specific individuals. I understand I may revoke or end this confidential communication at any time **in writing** by giving written notice of my decision to GEHA's contact listed below. I understand that my revocation of this confidential communication will not affect any action that GEHA has taken based upon this confidential communication before GEHA actually receives my request to revoke it. **PLEASE NOTE: The confidential communication will be valid even if you should terminate GEHA coverage. If you would then re-enroll at any time, the confidential communication would continue to remain valid unless you would revoke it in writing after re-enrollment.**

Date: _____

Patient or Legal Representative Signature: _____

Relationship to patient: _____
(i.e. parent, legal guardian, power of attorney, etc.)

NOTE: If the signature is not that of the patient or the parent when the child is a minor, appropriate legal documentation is required to accept the signature.

PLEASE RETAIN A COPY FOR YOUR RECORDS AND RETURN THE ORIGINAL SIGNED FORM TO:

GEHA
ATTN: Confidential Communication Request
P.O. Box 438
Independence, MO 64051-0438
FAX: 816-257-3283