



## Community Health Network of Washington Request for Confidential Communications

You have the right to request an alternative means of communication (e.g., regular mail, email, telephone, facsimile) of your protected health information (PHI) or communication of your PHI to an alternate location. This request for communications by alternative means or to an alternate location is applicable only to the information held by Community Health Network of Washington (CHNW) and disclosure by alternative means may not be protected and could endanger me. Confidential communication of PHI covered under this request includes (but is not limited to):

- An explanation of benefits (EOB) notice.
- Information about an appointment.
- A claim denial.
- A request for additional information about a claim.
- The name and address of a provider, a description of services provided, and any other visit information.

1. **Enrollee Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Enrollee ID Number:** \_\_\_\_\_ **Date of Request:** \_\_\_\_\_

**Enrollee Address:** \_\_\_\_\_

**Enrollee email:** \_\_\_\_\_

**Enrollee Phone:** \_\_\_\_\_ **Enrollee Fax:** \_\_\_\_\_

- Choose one:**  Ok to leave message with detailed information.  
 Leave message with call-back number only.

2. Check only one box below to tell CHNW the specific PHI to which this request applies:

**All PHI about the sensitive/protected services** I receive using my health insurance, including where and when I receive health care be sent directly to me by the alternative means or to the alternate location as outlined in Section 2 below.

**All information about the health care I receive** using my health insurance, including where and when I receive care be sent directly to me by the alternative means or to the alternate location as outlined in Section 2 below because disclosure of all or part of this information could lead to harm or could subject me to harassment or abuse. **(You will never be asked to explain why you feel this way.)**



**A specific date of service:** \_\_\_\_\_

**A specific period of time: From:** \_\_\_\_\_ **To:** \_\_\_\_\_

**3.** I request that communications containing any of the above information be sent to me as available as follows:

Email to: \_\_\_\_\_

Text message to: \_\_\_\_\_

Phone call to: \_\_\_\_\_

U.S. Mail to: \_\_\_\_\_

**4. IMPORTANT: the following MUST be completed:**

**4a.** If a communication cannot be sent in the above formats, or if you want information by U.S. mail, provide the address below:

\_\_\_\_\_

**4b.** Is there a phone number or email to use if there are questions about this request?

\_\_\_\_\_

**5.** I understand that it may take up to three business days from the date of receipt of this form for CHNW to process the request. I further understand that I may make this request by telephone to the customer service number listed below.

\_\_\_\_\_  
**Printed Name**

\_\_\_\_\_  
**Phone**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

Check here if you are signing as a personal representative and complete below. Please attach the appropriate documentation (e.g., Power of Attorney). This only applies if someone other than the enrollee signed above.



**COMMUNITY  
HEALTH NETWORK**  
of Washington™

Cascade Select

powered by  **COMMUNITY HEALTH PLAN**  
of Washington

**Telephone Number of Personal Representative:** \_\_\_\_\_

**Personal Representative's relationship to the enrollee:** \_\_\_\_\_

**4. Send the completed, signed request to:**

Community Health Network of Washington  
Attn: Customer Service Department  
1111 3<sup>rd</sup> Ave, Ste. 400  
Seattle, WA 98101  
Fax: (206) 652-7050  
Email: [CustomerCare@chpw.org](mailto:CustomerCare@chpw.org)

If you have any questions or to obtain a full notice of your privacy rights, contact CHNW's Customer Service department at the following

Contact Customer Service toll-free at 1-866-907-1906, Monday – Friday, from 8am to 5pm.

If you have hearing or speech impaired, please call TTY 711 (toll-free).

The notice is also available online at: <https://www.cascadeselect.org/member-center/member-rights/>