

OREGON REQUEST FOR CONFIDENTIAL COMMUNICATION

You have the right to have protected health information* sent to you instead of the person who pays for your health insurance plan. You can ask to be contacted:

- At a different mailing address
- By email
- By telephone

To make this request, complete, sign, and send this form to your insurer. You can send it by mail, fax, or email. To find contact information for your health insurance plan, visit <http://www.oregon.gov/DCBS/Insurance/gethelp/health/Pages/confidential-communications.aspx>.

Please note: It can take up to 30 days from the date your insurer receives your hard-copy request to process it. Requests made by telephone, by email, or over the Internet must be implemented by your insurer within seven days of receipt.

Name of your health insurance company

Your name

Your date of birth

Your insurance member # (if available)

Your insurance group # (if available)

Please tell us how we should contact you. If you mark more than one way, put a "1" next to your first choice, "2" next to your second choice, and so on. Your health plan must contact you through at least one of the communication methods noted below:

- Email to the following email address: _____
- U.S. Mail at this address: _____
- Text to the following phone #: _____
- Message through online insurance patient portal: _____
- Phone call to the following number: _____

IMPORTANT! The following two sections MUST be completed:

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

2. Is there a phone number or email to use if there are questions regarding this request?

Signature

Date

PLEASE NOTE: If you change insurance companies, you will need to make a new request to the new insurance company. Until your request is processed, the insurance company may continue to send your protected health insurance to the person who is paying for your health insurance.

You may send your confidential communication form to Providence Health Plan at:

Providence Health Plan
Attn: Customer Service
PO Box 4327
Portland, Oregon 97208-4327

You may fax your confidential communication form to 503-574-8731 or 1-800-425-0199 or you may hand deliver it (*if mailing, use only the post office box address listed above*) to the following address:

Providence Health Plan
Attn: Customer Service
3601 SW Murray Blvd. #10
Beaverton, Oregon 97005-2359

*Protected Health Information means individually identifiable health information your insurer has or sends out in any form. Confidential communication of protected health insurance covered under this request includes:

- An explanation of benefits notice
- Information about an appointment
- A claim denial
- A request for additional information about a claim
- A notice of a contested claim
- The name and address of a provider, a description of services provided, and other visit information
- Any written, oral, or electronic communication described on this list to a policyholder, certificate holder, or enrollee that contains protected health information

Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you are a member who needs these services, please call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158

If you need help filing a grievance, you can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights 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:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (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 1-800-878-4445 (TTY: 711)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم): (TTY: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតល្អល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

ف می باشد یا (TTY: 711) 1-800-878-4445 تماس بگیرید. شما برای رایگان بصورت زبانی تسهیلات، کنید می گفتگو فارسی زبان به اگر: توجه

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)