REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Instructions: To request confidential communications, please complete the information below, sign in the space provided and return to: Braven Health, Attn: HIPAA Team, P.O. Box 1458, Newark, New Jersey 07101-1458 or via fax at 973-274-2358.

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

Reason: ____

____

Signature*: ____ Date: ________/________/________

Member's Name: ____

Member's Date of Birth: ________/_______/_________

Subscriber Name: ________________________________ Subscriber Identification #: ________________

Do you have an alternate address you wish us to use: ☐ Yes ☐ No

If Yes, provide the address below. If No, Braven Health will keep all your mail and you will have to contact the Privacy Office to retrieve it.

Alternate Address: ____

City: ____ State: ____________ Zip: ____________

Password: __________________ (Must be 4 to 10 characters, letters or numbers, and a password only you will know)

Is there some other means we may use to contact you (e.g. phone or email) if necessary?

Phone #: ___________________________ Email Address: ___________________________________

* If someone other than the member is submitting this, sign your name and attach documentation showing you are authorized to act on behalf of the member.

Mail form to the following address or via fax at 973-274-2358:

Braven Health
Attn: HIPAA Team
P.O. Box 1458
Newark, NJ 07101-1458

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