Request for Confidential Communications of Protect Health Information

ASPIRUS HEALTH PLAN

You may request that your protected health information be delivered to a location that is not your address if sending the information to your address could ***endanger*** you. You may also request communications by different means (phone calls, emails) if our regular communications could endanger you. Please complete this form and we will review your request. We will either grant the request or explain the reason why the request was not granted.

NOTE: Aspirus Health Plan does not maintain original medical records. We advise members to contact their provider's office, clinic, or hospital to obtain medical records. Members must follow the provider's procedures for amending medical records.

Return completed form to: Aspirus Health Plan, ATTN: Legal/Privacy, PO Box 1890, Southampton, PA 18966
or email to: CustomerService@aspirushealthplan.com. If you have questions, please call Customer Service at: 866.631.5404.

PART A: MEMBER INFORMATION

Member Last Name	Member First Name	MI	Member Date of Birth
Member Street Address	City	State	Zip Code
Phone Number *(include area code)*	Cell Number *(include area code)*	Subscriber Number *(ID Card)*	

Complete the following only if the person making the request is not the member

Name of Requestor	Relationship to Member	Legal Authority*	Phone Number (include area code)
Address	City	State	Zip Code

PART B: REQUEST FOR CONFIDENTIAL COMMUNICATIONS OF PROTECTED HEALTH INFORMATION

You have the right to request Aspirus Health Plan communicate with you, all or some of your PHI, confidentially by alternative means or to an alternative location that you choose. Aspirus Health Plan will accommodate your request if:

A. It is reasonable;
B. You state that failure to communicate your PHI confidentially by the alternative means, or to the alternative location you specify, could endanger you;
C. You provide Aspirus Health Plan with a reasonable alternative means or location for communicating with you; and
D. You provide a satisfactory explanation of how any applicable enrollment premium, copayments, cost share, and other payments will be handled under the alternative means or location of your request.

Please describe the protected health information you want to include in the specific confidential communications.

PART C: ALTERNATIVE MEANS OF COMMUNICATION OR LOCATION

I request that Aspirus Health Plan use the following alternative means of communicating with me about my PHI. If I prefer mailing to a different location, I request that Aspirus Heatlh Plan communicate with me at the following alternative address. Please provide complete description and full information about alternative means you want Aspirus Heatlh Plan to use.

PART D: HANDLING OF COMMUNICATION

Please explain how any communications pertaining to enrollment premiums, copayments, cost-shares, and other payments will be handled
(Example: I check the mail at the alternate address I provided three times a week and will respond to bills received at that address).

PART E: MEMBER OR AUTHORIZED REPRESENTATIVE/GUARDIAN SIGNATURE

Member signature or Designated Legal Representative/Guardian signature	Date
X	
If authorized representative: (1) print your name, (2) state the legal authority for your status as Member's representative, and (3) attach supporting documentation:*	

*If you are the member's legally authorized representative as defined by HIPAA or other applicable federal and state law, you must submit the applicable documentation or other proof of legally authorized representative status that establishes your authority including but not limited to: **Power of Attorney** – Valid power of attorney document, **Guardian** – Valid court order appointing you as guardian, or **Executor** – Valid court order appointing you as executor of a decedent's estate. Legally authorized representatives must provide notice of any change to their status or authority.

Nondiscrimination & Language Access Policy

Discrimination is Against the Law. Aspirus Health Plan, Inc. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex, (including sex characteristics, including intersex traits; pregnancy or related conditions; sexual orientation, gender identity and sex stereotypes), consistent with the scope of sex discrimination described at 45 CFR § 92.101(a)(2). Aspirus Health Plan, Inc. does not exclude people or treat them less favorably because of race, color, national origin, age, disability, or sex.

Aspirus Health Plan, Inc.:
Provides people with disabilities reasonable modifications and free appropriate auxiliary aids and services to communicate effectively with us, such as:

- Qualified sign language interpreters.
- Written information in other formats (large print, audio, accessible electronic formats, other formats).

Provides free language assistance services to people whose primary language is not English, which may include:

- Qualified interpreters.
- Information written in other languages.

If *you* need reasonable modifications, appropriate auxiliary aids and services, or language assistance services, contact the Nondiscrimination Grievance Coordinator at the address, phone number, fax number, or email address below.

If *you* believe that Aspirus Health Plan, Inc. 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:

Nondiscrimination Grievance Coordinator
Aspirus Health Plan, Inc.
PO Box 1890
Southampton, PA 18966-9998
Phone: 1-866-631-5404 (TTY: 711)
Fax: 763-847-4010
Email: customerservice@aspirushealthplan.com

You can file a *grievance* in person or by mail, fax, or email. If *you* need help filing a *grievance*, the Nondiscrimination Grievance Coordinator is available to help *you*.

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, D.C. 20201
1.800.368.1019, 800.537.7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. This notice is available at Aspirus Health Plan, Inc.'s website: https://aspirushealthplan.com/webdocs/70021-AHP-NonDiscrim_Lang-Assist-Notice.pdf.

Language Assistance Services

Albanian: KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë.Telefononi në 1-866-631-5404 (TTY: 711).

Arabic تنبيه: إذا كنت تتحدث اللغة العربية، فإن خدمات المساعدة اللغوية متاحة لك مجاناً. اتصل بن اعلى رقم الهاتف1-866-631-5404(رقم هاتف الصم والبك : 711)

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-866-631-5404 (ATS: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zurVerfügung. Rufnummer: 1-866-631-5404 (TTY: 711).

Hindi: _यान द_ : य_द आप िहंदी बोलते ह_ तो आपके िलए मु_त म_ भाषा सहायता सेवाएं उपल_ध ह_। 1-866-631-5404 (TTY: 711) पर कॉल कर_।

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-866-631-5404 (TTY: 711).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.1-866-631-5404 (TTY: 711)번으로 전화해 주십시오.

Polish: UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer1-866-631-5404 (TTY: 711).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.Звоните 1-866-631-5404 (телетайп: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al1-866-631-5404 (TTY: 711).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nangwalang bayad. Tumawag sa 1-866-631-5404 (TTY: 711).

Traditional Chinese: 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 1-866-631-5404 (TTY: 711)

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-631-5404 (TTY: 711).

Pennsylvania Dutch: Wann du Deitsch (Pennsylvania German / Dutch) schwetzscht, kannscht du mitaus Koschte ebbergricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-866-631-5404 (TTY: 711).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ,ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-866-631-5404 (TTY: 711).