VERMONT
CENTER FOR CRIME VICTIM SERVICES

PATIENT STAMP

REQUEST FOR CONFIDENTIAL COMMUNICATION OF PROTECTED HEALTH INFORMATION (PHI) FOR BCBS-VT, MVP, AND CIGNA

Use this form to exercise your right under state and federal privacy laws to request that your health insurer use an alternative address when communicating with you about your protected health information (PHI).

STEP 1: TO BE COMPLETED BY THE PATIENT/MEMBER

My Name (patient/member) _____

My Health Insurer -check one ☐ BCBS-VT ☐ MVP ☐ Cigna

My Member ID Number _____ **My Date of Birth**_____

My relationship to the subscriber (self, spouse, child, etc.) _____

Primary Subscriber's mailing address _____

City_____ State_____ Zip Code_____

Because I am a victim of crime, I choose to receive my protected health information (PHI) by means of an alternative address to protect my safety/confidentiality. I request my health insurer communicate with me about **ALL** my protected health information (PHI) at the following alternative address: (Choose One)

☐ Mailing address_____City_____State_____Zip Code_____

☐ The Vermont Center for Crime Victim Services (VCCVS) 58 South Main Street, Suite 1, Waterbury, VT 05676-1599

- I understand this request is in effect until my health insurer no longer maintains my health information, or until I revoke this request by sending written notification to my health insurer clearly stating my intent to revoke this request and the effective date.
- I understand that if I choose the Vermont Center for Crime Victim Services as my alternative address, the Vermont Center for Crime Victim Services will not open or examine any communications(mail) from my health insurer unless I provide them with a written authorization to do so. I may obtain my communications(mail) from VCCVS by contacting the Sexual Assault Program: phone 1-802-241-1250 x104, fax 1-802-241-1253, or by mail Attention: Sexual Assault Program Coordinator at VCCVS; 58 Main Street, Suite 1, Waterbury, VT 05676-1599

Patient/Member
Signature (required)_____ **Date (required)**_____

STEP 2: TO BE COMPLETED BY THE SANE-SEXUAL ASSAULT NURSE EXAMINER

☐ This form was faxed to Member's Health insurer: (check below)

___**Cigna** fax 1-877-815-4827 or 1-859-410-2419 ___**MVP** fax 1-844-696-9770 ___**BCBS-VT** fax 1-866-529-8503

☐ This form was faxed to the Vermont Center for Crime Victim Services; fax 1-802-241-1253

☐ This form was provided to all: ___Patient ___Hospital Billing Dept. ___Patient Medical Record

_____ _____ _____

Form Distribution Completed by (print name) *Date* *Contact Phone Number*

FOR INSURANCE COMPANY USE

Please notify VCCVS Sexual Assault Program by email when this confidential communications request has been processed and is in effect: saprogram@ccvs.vermont.gov

Sexual Assault Program Coordinator, 58 South Main St., Suite 1, Waterbury, VT 05675-1599
Phone 802-241-1250 x104, Fax 802-241-1253

VERMONT
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INSTRUCTIONS FOR COMPLETING "REQUEST FOR CONFIDENTIAL COMMUNICATIONS OF PERSONAL HEALTH INFORMATION (PHI) FOR BCBS-VT, MVP, AND CIGNA"

STEP 1: TO BE COMPLETED BY THE PATIENT/MEMBER (Patient Instructions)

1. **My Name (Patient/Member)**- This is your name as written on your health insurance identification card. It may be different from the name of the primary subscriber. The primary subscriber is the individual who first signed up for the health insurance. For example, the primary subscriber may be your parent or spouse.
2. **My Health Insurer**- Check one. This form is only used for the three health insurers listed. Vermont Center for Crime Victim Services cannot facilitate a *Confidential Communication Request of Protected Health Information* for policies NOT based in Vermont. Vermont Medicaid does NOT utilize this form since they DO NOT send out confidential communications such as Explanation of Benefits (EOB's). If you have Vermont Medicaid, Out of State Insurance or No insurance DO NOT complete this form.
3. **My Member ID Number**- Provide your member ID number not Group Number. This number is on your health insurance identification card, usually next to the abbreviation "ID". If you do not have this number, your health insurer may be able to locate your policy based on your name and date of birth.
4. **Patient/Member Date of Birth**- Provide YOUR date of birth.
5. **My relationship to the subscriber**- If you signed up for your health insurance, you are the subscriber, write "self". If you are a member under someone else's insurance, what is your relationship to them?
6. **Primary Subscriber's Mailing Address**- This is this address of the primary subscriber and may or may not be your address. We will NOT contact the primary subscriber.
7. **Alternative Address**- Please choose only one of the two options:
   a. The first option allows your health insurer to mail documents with your protected health information to a "safe/alternative" address that you designate. Your documents will always go to this designated address until you (patient/member) contact your health insurer directly to make a change.
   b. The second option allows your health insurer to mail documents with your protected health information to the Vermont Center for Crime Victim Services (VCCVS). You may choose this option if you have no other "safe/alternative" address. VCCVS will NOT open your documents but will hold them for you. You MUST contact the Center for Crime Victim Services at (802) 241-1253 x 104 to obtain your documents. Your documents will always go to this designated address until you (patient/member) contact your health insurer directly to make a change.
8. **Patient/Member Signature and Date**- Your signature and the date are REQUIRED for your health insurer to legally process your request.

STEP 2: TO BE COMPLETED BY THE SANE (SANE Instructions)

1. Review this form to ensure the patient filled out all sections, signed, and dated.
2. Fax this form to the patient health insurer. **Cigna** fax 1-877-815-4827 or 1-859-410-2429, **MVP** fax 1-844-696-9770, **BCBS-VT** fax 1-800-247-2583
3. Fax this form to the Vermont Center for Crime Victim Services. VCCVS fax 1-802-241-1253
4. Give a copy of both sides of this form to the patient for future reference.
5. Document your name, contact number and the date that you submitted this form.

Sexual Assault Program Coordinator, 58 South Main St., Suite 1, Waterbury, VT 05675-1599
Phone 802-241-1250 x104, Fax 802-241-1253