SOUTH CAROLINA PUBLIC EMPLOYEE BENEFIT AUTHORITY
REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Please complete the following request form and return it to the South Carolina Public Employee Benefit Authority (PEBA) at the address listed below. If PEBA agrees to the confidential communications request, it will inform the third-party administrators that you designate on this form.

However, in order to request confidential communications from BlueCross BlueShield of South Carolina, Companion Benefit Alternatives and/or BlueChoice HealthPlan, you must contact them through the use of the form on the next page. Please note that you must send the BlueCross BlueShield form directly to the address listed on that form for your request to be processed by BlueCross BlueShield.

SECTION A: Individual requesting confidential communications.

Name: _____

Address: _____

Telephone: _____ Benefits Identification Number: _____

Email address: _____

SECTION B: To the individual—please read the following, and provide the information requested.

You have the right to request that we communicate about your Protected Health Information by alternative means or to an alternative location to avoid endangering you. We will accommodate your request if (a) it is reasonable, (b) you state clearly that failure to communicate your Protected Health Information by the alternative means or to the alternative location could endanger you, and (c) you provide reasonable alternative means or location for communicating with you.

❑ I request that you communicate with me about my Protected Health Information by alternative means. (Please provide full information on the alternative means you want PEBA to use.)

_____

_____

❑ I request that you communicate with me about my Protected Health Information at the following alternative location. (Please provide full information on the alternative location.)

_____

_____

INDIVIDUAL'S SIGNATURE

I attest that failure to communicate my PHI by the alternative means or to the alternative location I request could endanger me.

Signature: _____ Date: _____

If this request is by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS REQUEST. PLEASE RETURN THIS FORM TO:

PEBA HIPAA Privacy Officer
P.O. Box 11661
Columbia, SC 29211

PEBA Form 04-14-6

South Carolina

BlueCross BlueShield of South Carolina is an independent licensee of the Blue Cross and Blue Shield Association

CONFIDENTIAL COMMUNICATIONS REQUEST

BlueCross BlueShield of South Carolina

Purpose: This form is used for an individual's request that we use alternative means or an alternative location when communicating about protected health information.

SECTION A: Individual requesting confidential communications.

Name: _____

Address: _____

Telephone: _____ Identification Number: _____

SECTION B: To the individual—please read the following and provide the information requested.

You have the right to request that we communicate about your protected health information by alternative means or to an alternative location to avoid endangering you. We will accommodate your request if (a) it is reasonable, (b) you state clearly that failure to communicate your protected health information by the alternative means or to the alternative location could endanger you, and (c) you provide reasonable alternative means or location for communicating with you. We will not investigate the validity of your claim that failure to communications with you by the alternative means or location could endanger you.

☐ I request that you communicate with me about my protected health information by alternative means. (Please provide full information on the alternative means you want us to use)

_____

_____

☐ I request that you communicate with me about my protected health information at the following alternative location. Please provide full information on the alternative location:

_____

_____

INDIVIDUAL'S SIGNATURE.

I attest that failure to communicate my protected health information by the alternative means or to the alternative location I request could endanger me.

Signature: _____ Date: _____

If this request is by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to Individual: _____

YOU ARE ENTITLED TO A COPY OF THIS REQUEST.

PLEASE RETURN THIS FORM TO:

Vinnetta Osborne, HIPAA Privacy Official
P.O. Box 100300 (AX-G50)
Columbia, SC 29202