CONFIDENTIAL COMMUNICATIONS REQUEST FORM

Complete this form and return to: Privacy Compliance Administrator, Corporate Compliance, Capital District Physicians' Health Plan, Inc., 6 Wellness Way, Latham, NY 12110

NOT FOR USE WHERE REQUEST IS DUE TO THREAT OF HARM.
CONTACT CDPHP MEMBER SERVICES IN CASES OF THREAT OF HARM.

I. MEMBER INFORMATION

Date of request: _____ Date of Birth:_____

Name:_____

CDPHP Identification #:_____ Telephone Number:_____

II. ADDRESS INFORMATION

Confidential Address Request. I am requesting that all CDPHP mailings be sent to the following address:

_____

_____

Alternative Means of Communications. I am requesting to receive confidential communications from CDPHP in the following format:_____

III. DEPENDENT INFORMATION

I am requesting that the address on file with CDPHP be updated as indicated above for all of the members listed below:
Please note: In order for confidential addresses to be accepted for members 18 years old and older, each member must complete and sign a Confidential Communications Request Form.

_____	_____
Name (please print)	*CDPHP ID#*
_____	_____
Name (please print)	*CDPHP ID #*
_____	_____
Name (please print)	*CDPHP ID#*

IV. SIGNATURE

I am requesting this change in my capacity as *(select one):*
___ Self ___Parent ___Guardian ___Legal Representative *(attach signed authorization form)*
___Other (explain):_____

Signature of member
or legal representative_____ Date_____