MedicareBlue℠ Rx (PDP)
A Medicare Prescription Drug Plan

P.O. Box 3178
Scranton, PA 18505
YourMedicareSolutions.com

Confidential Communication Request

Please read these instructions carefully before completing this form.

When to Use this Form

Complete this form if you want MedicareBlue Rx (PDP) to use a different address when sending member communications including claim related material to you.

There may be others involved in your healthcare you may want to contact to make a similar request.

How to Complete this Form

The Confidential Communication Request form must be completed and signed by one of the following:

- The person asking for the confidential communications
- The personal representative of the person asking for the confidential communications (e.g., power of attorney, conservator, executor). If you have not already submitted this information, please attach appropriate documentation.

Note: If you wish to request a confidential communication for more than one member on a contract, you will need to fill out a separate form for each person.

To complete this form:

- Fill in the name, address, member ID of the person asking for the confidential communications
- Complete all necessary information
- Check the box requesting confidential communications
- Sign and date the form
- If you are not the person requesting confidential communications, state your relationship to that person.

Mail this Form to

MedicareBlue Rx (PDP)
P.O. Box 3178
Scranton, PA 18505

Confidential Communication Request

Member Information (person requesting confidential communications)

Name: _____

Address: _____

City: _____ State: _____ Zip Code _____

Member ID: _____ _____

I request that you send all member communication, including claim related material to the following alternative address:

Address: _____

City: _____ State: _____ Zip Code _____

☐ Please check this box to make a request for confidential communications. By checking this box and requesting confidential communications, you are affirming your belief that the disclosure of all or part of your information could put you in danger.

Right to Revoke

This request for confidential communication has no expiration date. I understand that I may cancel this request in writing at any time, but it will not affect any confidential communications released before I cancel it.

☐ Please check this box if you are exercising to your right to revoke your alternative address. All information related to your healthcare services will be sent to the contract holder's address currently in our records

_____ ___-___-____

Signature of Member Date

_____ ___-___-____

Signature of Personal Representative Date

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

Personal Representative's Name: _____

Relationship to Member: _____

Note: You have a right to keep a copy of this notice after you sign it.
We will complete your request within 30 days of our receipt.

Coverage is available to residents of the service area and separately issued by one of the following plans: Wellmark Blue Cross and Blue Shield of Iowa,* Blue Cross and Blue Shield of Minnesota,* Blue Cross and Blue Shield of Montana,* Blue Cross and Blue Shield of Nebraska,* Blue Cross Blue Shield of North Dakota,* Wellmark Blue Cross and Blue Shield of South Dakota,* and Blue Cross Blue Shield of Wyoming.*

*Independent licensees of the Blue Cross and Blue Shield Association.

S5743_080316_B01_RE Internal Approval 08/11/2016