
Request to Revoke or Change Prior Confidential Communication Request

You (or your personal representative) previously sent United Behavioral Health (UBH), or its affiliate U.S. Behavioral Health Plan of California (USBHPC), a request for confidential communication relating to your behavioral health benefits.

Use this form **only** if you would like to revoke or change the prior request to UBH that has been made to communicate with you at an alternate address or by alternate means. Please fill in the attached form and mail it back to the Privacy Lead at the address listed on the form.

If you choose to revoke your prior request for confidential communication, any Explanations of Benefits (EOBs) relating to the behavioral health benefits you access after the date you sign and return this form will be mailed to the Subscriber at his/her address. In addition, any letters relating to those benefits will be mailed to you at the Subscriber's address.

If you would like to continue to receive confidential treatment, but would like communications mailed to a different address, then all correspondence and EOBs mailed after the date of your request will be sent to the new address. UBH will continue to send all correspondence to you at this address until you revoke your confidential communication request or provide us with another address.

When completing this form, please:

- Complete all sections entirely (both front and back of form);
- Print information clearly;
- Provide us with your most current information.

Please note that we can only process your confidential communication request with respect to behavioral health benefits administered by United Behavioral Health or its affiliates. To obtain your confidential communication concerning your medical, dental or any other covered entity benefit not managed by UBH or its affiliates, you must contact the entity that administers those benefits directly.

If you have any questions about filling out this form, please contact 1-866-604-3273 and dial "0" to speak with a Customer Service Representative.

Request to Revoke or Change Prior Confidential Communication Request

This form is used to (i) revoke a prior request for confidential communication, or (ii) change the address and/or phone number at which you would like to receive confidential communications from United Behavioral Health. It must be completed in its entirety to ensure prompt and accurate processing. Please print. Be sure to fill out both sides of this form.

Section 1: Member's Current Information (as stated on prior Request for Confidential Communication):

Member Name _____ Address _____

City _____ State ____ Zip _____

Phone Number (____) - _____ Date of Birth _____ Male ____ Female ____

Relationship to Subscriber: Self ____ Spouse ____ Child ____ If other, describe type of relationship _____

Section 2: Revocation or Revision of Prior Request:

Please indicate whether you want to revoke or revise your prior request for confidential communication.

- I would like to **revoke** my prior request for confidential communication.
I understand that by revoking this request, EOBs relating to my behavioral health care will be sent to the Subscriber and that any other written correspondence about my behavioral health care will be sent to me at the Subscriber's address.
- I would like to **revise** my prior request for confidential communication and give UBH a new address and/or phone number.

If you are revising your prior request, please indicate the new address and/or phone number where you would like to receive all future communication from UBH about your behavioral health care:

Address _____

City _____ State ____ Zip _____

Phone Number (____) _____

Phone number where we can reach you if we have questions about this form: (____) _____

Section 3: Signature of Member or His/Her Personal Representative

Authorized signature of the individual, or personal representative of the individual, for whom confidential communication is being requested:

I want UBH to communicate with me at the address or phone number, or in the manner requested, as listed above.

Signature of Individual: X _____ Date _____

Signature of Parent/Personal Representative (if applicable): X _____ Date _____

Parent/Representative's Name _____ Address _____

City _____ State ____ Zip _____ Phone Number (____) _____

Relationship to individual and authority to act for individual _____

Important: A personal representative, including a parent, legal guardian, or executor of an estate, may be required to attach a copy of legal documentation to this request form. If you have questions please call 1-866-604-3273 and dial "0" to speak with a Customer Service Representative who can answer your questions about legal documentation.

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Section 4: United Behavioral Health Subscriber Identification (to ensure accurate processing)

Subscriber Identification Number _____ Group Number _____ Employer _____

Subscriber Name _____ Address _____

City _____ State _____ Zip _____ Phone Number (_____) _____

Please return the completed form to:

United Behavioral Health
Compliance Department
P.O. Box 99378
Emeryville, CA 94662-9378