# Update Method of Confidential Communication

WyoBLUE ADVANTAGE
An independent licensee of the Blue Cross Blue Shield Association

If you currently have confidential communication in place, use this form to change the method we use to communicate your protected health information. *(If you wish to begin confidential communication, you will need to use the form "Request for Confidential Communication.")*

## A Please identify the MEMBER who has confidential communication

**Member name** _____ **Date of birth** _____

**Member ID** (number on ID card beginning with 1 to 3 letters) _____

## B Current address of SUBSCRIBER *(Complete using the enrollment information we have on record).*

**Subscriber address** _____

**City** _____ **State** _____ **ZIP** _____

## C Address/telephone number CURRENTLY being used for confidential communication

**Member address** _____

**City** _____ **State** _____ **ZIP** _____

**In care of:** *(optional)* _____

**Telephone number** _____

## D New address/telephone number to be used for confidential communication

**Member address** _____

**City** _____ **State** _____ **ZIP** _____

**In care of:** *(optional)* _____

**Telephone number** _____

## E Signature *(Please sign and date the appropriate line)*

***Note: Complete form by signing in EITHER Section 1 or Section 2 (on the following page).***

### 1 If you are the MEMBER requesting confidential communication

SIGN HERE _____ **Date** _____



*Continued on following page.*

## E Signature *continued*

### 2 If you are the member's PERSONAL REPRESENTATIVE

Please provide your name, sign and date. Check the box that best describes your relationship to the member. If it is not already on file, **attach proof of your relationship to the member**. Parents do not need to attach proof.

**Representative's full name** _____

**SIGN HERE** _____ **Date** _____

- ☐ Parent of minor (younger than 18) child.
- ☐ Legal guardian: *Attach guardianship documentation (must have a court's stamp and signature).*
- ☐ Power of attorney: *Attach power of attorney (**must include** authorization of the release of healthcare information).*
- ☐ Executor: *Attach letter of appointment of executorship (must have a court's stamp and signature).*
- ☐ Patient Advocate: *Attach Designation of Patient Advocate form, signed by member.*

Please mail completed form (and documentation if needed) to:

**Customer Individual Rights Unit**
**600 East Lafayette, MC 1620**
**Detroit, MI 48226-2998**

Or fax to: **1-877-522-4767**