

CONFIDENTIAL COMMUNICATIONS FORM
PRIVACY & CONFIDENTIALITY REQUEST FORM

(MEMB)
P.O. Box 100234
Columbia, SC 29202-3234

Please complete all sections of this form.

I am requesting that all communications regarding my personal health information be kept confidential, and are sent to a different address. All future communications should be sent to the address I have listed below.

Your General Information

**required information*

Last Name*: _____
 First Name*: _____ Middle Initial: _____
 Carolina Care Plan ID Number*: _____ Birth Date (MM/DD/YY):
 ____/____/_____
 Group Number*: _____

Request for Confidential Communication – Designating Different Address

Please fill in the location to where your communications are to be sent. Note: Carolina Care Plan will send a letter to you at this new address to confirm that your request has been processed.

Street*: _____
 City*: _____ State*: _____ Zip Code*: _____

Reason for Request*:

Age Requirements: Requestor must be age 18 or greater unless requestor qualifies to receive medical care or treatment without prior parental consent under applicable state law. Individuals under the age of 18 should provide evidence of their ability to access medical care or treatment without the prior consent of a parent or supervising adult. Individuals under the age 15 are not eligible for confidential communication.

Your Signature* _____
 Date*: _____

For more information, refer to the Carolina Care Plan Privacy Notice located at CarolinaCarePlan.com or, to receive a copy, call the Customer Service telephone number on the back of your identification card.

Send completed and signed form to: Carolina Care Plan
 P.O. Box 100234
 Columbia, SC 29202-3234