CONFIDENTIAL COMMUNICATIONS REQUEST FORM

You have the right to have your Confidential Healthcare Information* sent directly to you instead of to the person who pays for your health insurance plan. For instance, you can request your Confidential Healthcare Information be sent to a specific address, email, or phone number of your choosing.

To make this request, you must complete all fields on the form below, sign and mail or max the form to us at:

Return this completed form to:

Address: SIMNSA Health Plan

2088 Otay Lakes Rd #102

Chula Vista, CA 91913

Fax: (619)407-4087

You may also request this by calling member services at 800-424-4652.

Please note: Your request will be complete within 7 calendar days of receipt of an electronic or telephonic request or within 14 days of receipt by first-class mail.

*. "Confidential Healthcare Information" means all health care services related to mental or behavioral health, sexual and reproductive health, sexually transmitted infections, substance use disorder, gender affirming care, and intimate partner violence. The member may request confidential communications related to any billing, benefit determination, explanation of benefit, request for additional information, contested claim, provider referral, or any other written, oral, or electronic communication containing protected health information related to "confidential information"

SIMNSA

1. Your Information

Your first name	Middle initial	Last name
Your member ID number	Birth date (*MM/DD/YYYY*)	Phone number
Your street	City, State, ZIP code	

Tell us how we should contact you. Some laws may require certain communications to be in writing, so an alternate mailing address is required to ensure confidentiality. We will send communications to your email address only if permitted by law.

2. Preferred Contact

☐	U.S. mail at this address: (Required)	
☐	Email at this email address:	
☐	Phone call to the following number:	
☐	Send to my authorized representative: (provide name & contact information)	

IMPORTANT! The following section MUST be completed:

3. Provide a phone number or email address to contact you if there are questions about this request.

Phone number	Email address

4. Your signature or your legal representative's signature

Signature	Date:
Printed Name:	

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