WPS HEALTH SOLUTIONS WPS HEALTH INSURANCE Arise HEALTH PLAN EPIC SPECIALTY BENEFITS

REQUEST FOR CONFIDENTIAL COMMUNICATIONS OF PROTECTED HEALTH INFORMATION

You have the right to request that protected health information about you that is maintained by Wisconsin Physicians Services Insurance Corporation (WPS or WPS Health Insurance), and/or its wholly owned subsidiaries, The EPIC Life Insurance Company (EPIC Specialty Benefits), and WPS Health Plan, Inc. (Arise Health Plan) (hereinafter "WPS Health Solutions") be communicated to you by alternative means or at alternative locations, if a disclosure of your personal health information could ***endanger*** you. We will review your request and will either grant it or explain the reason why the request was not granted. ***NOTE: WPS Health Solutions does not maintain original medical records. We advise members to contact their provider's office, clinic or hospital to obtain medical records. Members must follow the provider's procedures for amending medical records.**

PART A: MEMBER INFORMATION

Member Last Name	Member First Name	M. I.	Member Date of Birth
Member Street Address	City	State	Zip Code
Phone # (including area code)	Cell Phone# (including area code)	Subscriber Number (ID Card)	

***** Complete the following only if the person making the request is not the member *****

Name of Requestor	Relationship to member	Legal Authority
Address		Phone Number

PART B: REQUEST FOR CONFIDENTIAL COMMUNICATIONS OF PROTECTED HEALTH INFORMATION

You have the right to request WPS Health Solutions communicate with you, all or part of your PHI, in confidence by alternative means or to an alternative location that you specify. WPS Health Solutions will accommodate your request if:.

A. It is reasonable
B. You represent that failure to communicate your PHI in confidence by the alternative means, or to the alternative location you specify, could endanger you,
C. You provide WPS Health Solutions with a reasonable alternative means or location for communicating with you, and
D. You provide a satisfactory explanation of how any applicable enrollment premium, co-payments, cost share and other payments will be handled under the alternative means or location of your request

Please describe the protected health information you want to include in the specific confidential communications.

Please explain how any communications pertaining to enrollment premiums, co-payments, cost-shares, and other payments will be handled.

PART C: MEMBER SIGNATURE OR AUTHORIZED REPRESENTATIVE/GUARDIAN

I request that WPS Health Solutions use the following alternative means of communicating with me about my PHI. *(Please provide complete description and full information about alternative means you want WPS Health Solutions to use):*

PART D: ALTERNATIVE LOCATION OF COMMUNICATION

I request that WPS Health Solutions communicate with me about my protected health information at the following alternative location. *Please provide full information about alternative location):*

PART E: MEMBER SIGNATURE OR AUTHORIZED REPRESENTATIVE/GUARDIAN

Member signature or Designated Legal Representative/Guardian signature **X**	**Date**

If authorized representative: (1) print your name, (2) state the legal authority for your status as Member's representative, and (3) attach supporting documentation:

Email: WPSprivacyofficer@wpsic.com **Mail:** Legal/Privacy, P.O. Box 8190, Madison, WI 53708-8190 **Fax:** (608) 977 - 9885