Request to Revoke or Change Existing Confidential Communication

This form is used to request a change or to revoke an existing confidential communication. Please fill in the attached form and return it via fax or to the address listed below.

If you would like your existing confidential communication to remain in place, but have a new address, be sure to check the appropriate box in section 3 to *change* the address. All correspondence will be sent to you at the new address until you revoke your confidential communication request or provide us with another address.

If you choose to revoke your prior request for confidential communication, any Explanations of Benefits (EOBs) or other correspondence will be mailed to the policy holder's address.

When completing this form, please:

- Complete all sections entirely;
- Print information clearly;
- Provide us with your most current information;
- Be sure to sign and date the form; and
- Include an alternate address for mailings if you are submitting a change request (this cannot be the same address as the subscriber or the same address as the one already on file for you).

Please note: If you are a guardian or court appointed representative for the individual you must attach copies of your authorization to represent the individual in order to obtain access to the individual's Protected Health Information (PHI).

Please note that we can only process your request to revoke or change a confidential communication with respect to benefits and programs we administer. If you would like to revoke or change a confidential communication beyond your behavioral health and Employee Assistance Program (EAP) healthcare information covered by this form, you must contact the entity that administers those benefits directly.

If you have any questions about filling out this form, please contact a Customer Service Representative at the number on the back of your identification card.

This Request to Revoke or Change Existing Confidential Communication form is for use by UnitedHealthcare and Optum members and their personal representatives. UnitedHealthcare behavioral health benefits are managed by Optum.

Please return the completed form to:
Fax: 888-371-7011
Or
Mail to:
Privacy Administrator
MN101-E013
11000 Optum Circle
Eden Prairie MN 55344

Request to Revoke or Change Existing Confidential Communication

This form is used to request a change or to revoke an existing confidential communication. Please complete the form and mail or fax as indicated below. It must be completed in its entirety to ensure prompt and accurate processing. Please print.

Section 1: Subscriber Identification

Identification Number ________________________ Group Number________________ Employer______________________________

Subscriber Name ____

Address ____

City____________ State_____ Zip_________ Phone (_______) ____

Section 2: Member's Current Information (person the Confidential Communication is for):

Member Name_________________________________Address____

City____ State____ Zip ____________ Phone (_____) -__________________________

Date of Birth ___________________ Male ___ Female___

Relationship to Subscriber: Self____ Spouse ____ Child____ If other, describe type of relationship _____________________________

Section 3: Revocation or Revision of Prior Request:

Please indicate whether you want to revoke or change your existing confidential communication.

- ❑ I would like to **revoke** my existing confidential communication.
  I understand that by revoking this request any Explanations of Benefits (EOBs) or other correspondence will be mailed to the policy holder's address.
- ❑ I would like to **change** my existing confidential communication and provide a new address and/or phone number.

If you are changing your existing request, please indicate the new address and/or phone number where you would like to receive communications:

Address ____

City_______________________________________ State __________Zip ____________Phone Number (_____) __________________

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

Section 4: Signature of Member or His/Her Personal Representative

I want to be communicated with at the address and/or phone number provided, or in the manner that I have indicated above.

Signature of Individual: X ____Date___________________________________

Please note: If you are a guardian or court appointed representative for the individual, you must attach copies of your authorization to represent the individual in order for this request to be processed.

Signature of Personal Representative if applicable: X ____ Date____________

Personal Representative's Name ______________________________Address:____

City____ State _______Zip_____ _______ Phone (_____) -___________________

Relationship to individual and authority to act for individual: ____