First MEDICAL HEALTH PLAN, INC.

Confidential Communication Request Form

By completing this form, you are requesting that we communicate all or part of your Protected Health Information (PHI) through alternative means or to an alternative location. We will accommodate your request if it is reasonable and you provide a reasonable alternative method or location for us to contact you.

You may submit your request by addressing it to the **Chief Compliance and Privacy Officer of First Medical Health Plan, Inc., PO Box 191580, San Juan, PR 00919-1580**, or by email: cumplimiento@firstmedicalpr.com, by fax 787-300-3913, or deliver it directly to any First Medical Health Plan, Inc. Service Office.

I. Beneficiary/Subscriber Information:		
Name:	Middle name:	Last Name:
Plan Identification Number/Contract Number:		Email: ☐ I authorize FMHP to send information to my email securely (Encrypted) manner

II. Specify Alternative Means for the Confidential Communication requested:

☐ Alternate Mailing Address: _____

☐ Alternate Phone Number: _____

☐ Alternate Email: _____

III. Could communicating your Protected Health Information through the specified alternative means or to the alternative location pose a risk to you? ☐ YES ☐ NO

IV. I understand and agree with the following:

- First Medical is not legally obligated to accept my request but will make every effort to accommodate reasonable requests for alternative communication methods and your right to alternate communications.
- I must notify First Medical if I wish to modify this Alternate Communication Request.
- This request is valid until I submit a revocation or a new request.
- This form only applies to communications from First Medical and does not apply to communications you may receive from other entities.

VI. Signature

Beneficiary/Subscriber Signature:	Date:

If you are a Legal Representative of the Beneficiary/Subscriber, you must:

1. Enter your full name: _____
2. Describe your authority to act for the Beneficiary/Subscriber (e.g.: Power of Attorney, Court Order or Medical Certification):

   _____
3. Provide a copy of the legal document naming you as Legal Representative. A Social Security representation document is not acceptable for the purpose of this form (please request assistance from a Customer Service Representative).

Signature of Legal Representative: _____ Date: _____

For Exclusive Use of FMHP Compliance Department-Privacy Unit	
Date Received:	Application: ☐ Accepted ☐ Denied

If denied, specify the reason(s) (Check one):

☐ The request is not reasonable to accommodate
☐ Alternate address or contact not provided
☐ Other (Please specify) _____

_____
Signature of the Privacy Unit Representative

If you need additional information, please contact the First Medical Health Plan, Inc.'s Privacy Unit at 787-474-3999, extension 2108/2583. We are available Monday through Friday from 8:00 a.m. to 5:00 p.m.

The Customer Service Department offers free language interpreter services and sign language. This includes services in alternate formats such as Braille, large print, and translation to other languages, verbally or written, among others. If you need plan information in another format or language, please contact our Customer Service Department at the number on the back of your plan card.

El Departamento de Servicio al Cliente ofrece servicios de intérprete de idiomas y lenguaje de señas libre de costo. Esto incluye, servicio de formatos alternos tales como: Braille, letra agrandada y traducción a otros idiomas, verbal o escrito, entre otros. Si usted necesita información del plan en otro formato o lenguaje, por favor comuníquese con nuestro Departamento de Servicio al Cliente al número que aparece al dorso de su tarjeta del plan.

First Medical *cumple con las leyes federales aplicables de derechos civiles y no discrimina en base a raza, color, origen de nacionalidad, edad, discapacidad, o sexo*. **First Medical** *complies with applicable federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, or sex.*

First Medical *遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人*