Request for Confidential Communications

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) and the California Confidentiality of Medical Information Act, you may request that Community Care Health (CCH) and its business associates communicate with you using an alternate address or other means of contact. You may use this form to make this request and mail it to us at the address on the following page. You may also send us an email with all of the below information to: customerservice@communitycarehealth.org. If you send your request by email, please include the words “Request for Confidential Communications” in your email subject line.

CCH will make every effort to comply with your request. We will notify you if your request cannot be reasonably accommodated. If accepted, we will implement your request within 14 days of receipt by U.S. mail or within 7 calendar days of receipt by email.

If you wish to change or revoke this request, you must submit a new Request for Confidential Communications or write to us.

If you have any questions regarding the process to request confidential communications, please contact Customer Service at (559) 724-4995.

Please complete the following:

Member Name: _____

Member ID # as shown on your CCH ID card: _____

Member Date of Birth: _____/_____/_____

Indicate below the alternative address where you prefer we send correspondence:

Street or PO Box _____

City _____State _____ Zip _____

Indicate below the phone number and/or email you prefer we use to contact you:

Phone Number: (_____) _____ - _____

Email: _____

If applicable, please provide below any additional information regarding the form or format in which you would like us to communicate with you. We will provide the information if it is readily producible in the form or format you request.

Provide your name, signature and date:

Print Name: _____

Signature: _____ Date: _____

Relationship to Member*: _____

* If you are not the Member or parent of the Member, please include proof of your legal authority to act on behalf of the Member specifically for matters related to the Member's health. You may submit one of the following or other legal document.

☑ HIPAA Authorization

☑ Power of Attorney for Health Care

☑ Legal Guardianship documentation from court or other authorized agency

Send this form to:

Community Care Health

ATTN: Privacy Officer

PO Box 45016

Fresno, CA 93718

GRIEVANCE/COMPLAINT FORM INSTRUCTION SHEET

If you have questions, call the Help Center at 1-888-466-2219 or TDD at 1-877-688-9891. This call is free.

How to File:

1. File online at www.HealthHelp.ca.gov. [This is the fastest way.]
   OR
   Fill out and sign the Cancellation of Health Care Coverage Grievance Form.
2. If you want someone to help you with your grievance, complete the Authorized Assistant Form.
3. Include documents requested on the Cancellation of Health Care Coverage Grievance Form, such as notices from your health plan, billing statements, and proof of payment.
4. If you are not submitting online, please mail or fax your form and any supporting documents to:
   Department of Managed Health Care
   Help Center
   980 9th Street, Suite 500
   Sacramento, CA 95814-2725
   Fax: (916) 255-5241

What Happens Next?

The Help Center will send you a letter telling you if your grievance has been accepted. If your grievance is accepted, a decision about your issue will be made within 30 days. You will be notified in writing of the decision.

INFORMATION PRACTICES ACT OF 1977 NOTICE

The Information Practices Act of 1977 (California Civil Code section 1798.17) requires the following notice.

- California's Knox-Keene Act gives the DMHC the authority to regulate health plans and investigate the grievances of health plan members.
- The DMHC's Help Center uses your personal information to investigate your problem with your health plan.
- You provide the DMHC this information voluntarily. You do not have to provide this information. However, if you do not, the DMHC may not be able to investigate your grievance.
- The DMHC may share your personal information, as needed, with the plan and providers to investigate your grievance.
- The DMHC may also share your information with other government agencies as required or allowed by law.
- You have a right to see your personal information. To do this, contact the DMHC Records Request Coordinator, DMHC, Office of Legal Services, 980 9th Street Suite 500, Sacramento CA 95814-2725, or call (916) 322-6727.