CONFIDENTIAL COMMUNICATIONS FOR PROTECTED HEALTH INFORMATION

The purpose of this form is to provide a member of The Health Plan of West Virginia (THP) with the opportunity to request alternate means or locations of communication about the member's protected health information (PHI).

<table>
<tr><td colspan="3">Member Name:</td></tr>
<tr><td colspan="3">Address:</td></tr>
<tr><td>City:</td><td>State:</td><td>Zip Code:</td></tr>
<tr><td>Date of Birth:</td><td colspan="2">Plan ID Number:</td></tr>
<tr><td>Phone Number:</td><td colspan="2">Email Address:</td></tr>
<tr><td colspan="2">Member Signature:</td><td>Date:</td></tr>
<tr><td colspan="2">Legal Representative Signature:
(if applicable)</td><td>Date:</td></tr>
<tr><td colspan="3">Relationship to Member:</td></tr>
</table>

List the specific information you want sent by an alternative means or an alternate location:

Provide how you would like to receive communications from THP about your PHI:

How long do you want this alternative communication to last? ______________________________

☐ Release of my PHI may harm or endanger me or other people

Submit this form to The Health Plan of West Virginia, 1110 Main Street, Wheeling WV 26003 Attn: Compliance Department or email to HIPAA@healthplan.org. We will notify you in writing if we are able to accommodate your request.

V062022