BlueCross BlueShield
Federal Employee Program

Healthcare Information Non-Disclosure Request

The Federal Employee Program sometimes needs to disclose (share or give out) your protected personal information (PPI). Use this form to ask us not to share your PPI with someone that you name. We will respond to all reasonable requests.

For address changes (e.g., primary residence, changes in custody/location of minor, college students, vacation addresses, etc.), please call Customer Service at the number on the back of your member ID card.

This form must be filled out completely before it can be processed. We will act upon your request within 15 working days of its receipt.

A. IDENTITY of MEMBER

Member Name: _____ **Date of Birth**: _____
(First/MI/Last) (MM/DD/YY)

Member #: _____

Current Address: _____ **City:** _____

State: _____ **ZIP:** _____ **Phone:** _____

Subscriber Name: _____
(First/MI/Last)

B. WHOM SHOULD WE NOT SHARE YOUR PPI WITH?

This request must identify a specific person. If this person is a healthcare provider, we may need to share your PPI for the payment of healthcare services rendered to you by that provider.

Name: _____ **Relationship to Member:** ☐ Spouse/Domestic Partner
☐ Parent/Legal Guardian* ☐ Previous Healthcare Provider ☐ Other (Please describe): _____

C. ALTERNATE MAILING ADDRESS

Where do you want us to send written information for you or your child(ren) (e.g., Explanations of Benefits):

☐ To your current address listed as in section A
☐ Alternate mailing address (please complete below):

Alternate Address: _____

City: _____ State: _____ ZIP: _____

☐ Alternate Telephone Number to be contacted at _____

D. INFORMATION NOT TO DISCLOSE

Check which types of PPI you do not want disclosed:

☐ Alcohol/Chemical Dependency
☐ Reproductive Health (including abortion)
☐ Mental Health
☐ Sexually Transmitted Disease (including HIV/AIDS)
☐ General Health Information
☐ Genetic Information

Note: To respond to your request, we may need to omit other types of PPI, as well.

E. PAYMENT

You must still pay for all costs related to your health plan. These include deductibles, copayments, coinsurance and any non-covered charges owed to providers.

F. DURATION OF THIS REQUEST

This request applies only to your current health plan. It stays in effect unless you notify us in writing. We may have already shared your PPI with the person named in Section B before we received this request or while we were acting on it. We are not liable for these disclosures.

IMPORTANT: We will deny or stop acting on a request that includes any minor children, if that request does not agree with court orders or documents.

*Sign your name: _____ Date: _____

*Print your name: _____

*If not the member, I am the: ☐ Parent ☐ Legal Guardian ☐ Holder of Power of Attorney/Legal Representative
If you are the legal guardian or holder of a power of attorney/legal representative for the member, please attach legal documentation.

When fully completed, fax or mail this form to:

Federal Employee Program
P.O. Box 91058
Seattle, WA 98111-9158

Fax: 877-202-3149

For office use only—Date received: _____ Received by (initials):_____