



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 mail it back 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. OptumHealth Care Solutions (branded as Optum) will send all correspondence 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
- Include an alternate address for mailings if you are submitting a change request (this can not 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.

Please note that we can only process your request to revoke or change a confidential communication with respect to benefits and programs administered by Optum or its affiliates. To revoke or change a confidential communication concerning benefits not managed by Optum or its affiliates, you must contact the entity that administers those benefits and programs 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.

Please return the completed form to:

Fax: 888-371-7011

Or

Mail to:

Optum 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 fill in the attached 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 OptumHealth Care Solutions (branded as Optum) 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 from Optum:

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 Optum to communicate with me at the address, phone number, 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: _____