Optum Frontier Therapies™

Request for confidential communications at an alternative address or by another means

Optum Frontier Therapies ® will occasionally provide you with confidential communications regarding the services you receive. Complete this form to:

1. Ask to get mail or phone calls at locations other than your home
2. Change or remove a prior confidential communication request, or
3. Ask to get your protected health information (PHI) in a different way.

We will accommodate reasonable requests. If you are interested in redirecting other confidential communications or need to update the address or phone number on file with your plan, please contact your plan directly. This form applies only to confidential communications from Optum Frontier Therapies.

Call us at the telephone number located on your pharmacy materials to:

- Request an initial confidential communication verbally
- Update general account information, including standard address and phone number changes
- Opt-out of communications
- Ask questions about this form

Once a confidential communication is in place, we will send written materials to the alternative address and/or call you at the alternative phone number you supplied. We will continue to use this alternative contact information until you tell us not to in writing; you will not be able to update your information through the usual enrollment/eligibility process and you must submit a change or revoke request via this form.

Submitting a request on behalf of another individual

Please have the **member** sign and submit the request if:

1. you are not the legal representative, OR
2. the individual is 12 or older, and the records may relate to sensitive health information, such as mental health, substance use, HIV/AIDs, STD, pregnancy, or reproductive health.

If you qualify as a legal representative, you are required to attach supporting documentation:

- **Power of attorney, Court Order, or another valid document**
- **HIPAA authorizations do not establish legal authority and are not sufficient to submit a request through this process**

Please note: If your request is granted, the confidential communication will only apply to services administered by Optum Frontier Therapies.

Mail the completed form to:

Optum Frontier Therapies
6425 Santa Margarita Street, Unit 110
Las Vegas, NV 89118

Fax: **1-866-991-9929**

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Please complete each section below. Forms submitted with incomplete information, insufficient legal authority, or signed by the incorrect individual may be denied or result in processing delays.

I am submitting this request for: ☐ Myself ☐ Minor child ☐ Someone else

Describe your relationship to the patient:

Preferred contact method: ☐ Home phone ☐ Mobile phone

☐ Email

1 Patient information (please provide current information)

Last name First name MI

Mailing street address Apt. #

City State ZIP

Date of birth (mm/dd/yyyy) Phone number with area code

2 Legal representative information (required if requestor is not the patient)

Last name First name MI

Mailing street address Apt. #

City State ZIP

Relationship to patient Phone number with area code

3 Alternative address or means

Would you like to create a new request or change or revoke an existing request?

☐ New Request. Please describe:

☐ Update existing request. Please describe:

☐ Revoke existing request. I understand that by revoking this request all future communications will be directed to the original contact information on file.

Please indicate the new address and/or phone number where you would like to receive communications from Optum Frontier Therapies, or state the alternative means you would like Optum Frontier Therapies to use when communicating with you (if applicable). We will accommodate reasonable requests.

Address Apt. #

City State ZIP

Phone number with area code

Please state the alternative means you would like Optum Frontier Therapies to use when communicating with you (if applicable)

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4 Select where to receive a response

Send a response to me as indicated below (select one response):

○ **Option 1:** PDF sent via secure email to this email address:

○ **Option 2:** Paper copy sent by mail to the address below if different than Section 1

Mailing street address Apt. #

City State ZIP

○ **Option 3:** Other readily available electronic format

Please describe:

5 Patient or legal representative signature

I want Optum Frontier Therapies to communicate with me as identified above.

X Patient or legal representative signature Date

6 Please mail the completed form to

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