Confidential Communications Request Form

Managed Health Network (MHN) wants you to know that you have a choice about your protected health information (PHI). You can have MHN send any communication involving Sensitive Services that has PHI directly to you instead of to the main subscriberof your family's health policy.

California law states: "'Sensitive Services' means all health care services related to mental or behavioral health … [or] substance use disorder...obtained by a patient at or above the minimum age specified for consenting to the service…." There are also other Sensitive Services that are covered by medical/surgical health insurance and not by MHN.

Adults 18 and older can consent to care and arrange to have these communications sent directly to them. Please use the attached form and the mail or email method below.

Minors aged 12 to 17 ***may*** be able to have communications sent directly to them, depending on the service type and other factors. Please call MHN at 1 888-327-0010 or the phone number on the subscriber's ID card to arrange for direct communications. You may also use the attached form and the related method below, but we encourage you to call us. For requests made by phone, we process your request within 7 days.

PHI is health information about you. Examples of communications that include PHI are:

- Explanation of Benefits (EOBs) – a statement about what MHN has paid for your services.
- Information about your appointments.
- Claim denials, requests for more information about claims, and notices of contested claims.
- The name and address of your provider, descriptions of services provided and other visit information.

Complete this form if you'd like us to send communications that contain PHI straight to you, instead of the subscriber. Communications will be sent to your specified mailing address or email. (**Please note**, not all communication can be sent to you via email, so include your desired mailing address too). If you wish to view the information given above online, please visit MHN's member website at www.mhn.com/members.

Please mail or email this finished form to MHN.

Allow up to 7 days for emailed requests and 14 days after receipt of mailed requests for processing.

Mail: MHN NSU
P.O. Box 10697
San Rafael, CA 94912

Email: AuthorizationforDisclosure@healthnet.com

We're here to help!

Please call if you have questions.

Phone: Call the phone number on your member ID card or 1 888-327-0010

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MHN

Your information:

First name:	Last name:	Birthdate:
Subscriber ID number and/or Employer Group Name:	Phone number: *Where to call you if we have questions?*	

Yes! Please send communications with my PHI to this mailing address and/or email address:

Mailing address:		
City:	State:	ZIP:
Email address:		

I certify and acknowledge that the above information is true and correct:

Signature:	Date:

Note: The Confidential Communications request shall be valid until the member submits a revocation of the request or a new Confidential Communications request is submitted.

If you are signing for the member, describe your relationship below. If you are the member's personal representative, describe this below and send us copies of those forms (such as power of attorney or order of guardianship).

I certify and acknowledge that the above information is true and correct:

Personal Representative Name: (Please print)

Describe the relationship:

Relationship to the member: (Please print)

Personal Representative Signature:

Signature:	Date: