Request to Revoke or Change Prior Confidential Communication Request

You (or your personal representative) previously sent UMR a request for a confidential communication relating to your benefits.

Use this form **only** if you would like to revoke or change the prior request to UMR that has been made to communicate with you at an alternate address or by alternate means. Please fill in the attached form and mail it back to the address listed on the end of this form.

If you choose to revoke your prior request for confidential communication, any Explanations of Benefits (EOBs) relating to the benefits you access after the date you sign and return this form will be mailed to the Subscriber at his/her address. In addition, any letters relating to those benefits will be mailed to you at the Subscriber's address.

If you would like to continue to receive confidential treatment, but would like communications mailed to a different address, then all correspondence and EOBs mailed after the date of your request will be sent to the new address. UMR will continue to send all correspondence to you at this address until you revoke your confidential communication request or provide us with another address.

When completing this form, please:

- Complete all sections entirely (both front and back of form);
- Print information clearly;
- Provide us with your most current information.

Please note that we can only process your confidential communication request with respect to benefits administered by UMR. To obtain a confidential communication concerning your benefit not managed by UMR, you must contact the entity that administers those benefits directly.

Request to Revoke or Change Prior Confidential Communication Request

This form is used to (i) revoke a prior request for confidential communication, or (ii) change the address and/or phone number at which you would like to receive confidential communications from UMR. It must be completed in its entirety to ensure prompt and accurate processing. Please print. Be sure to fill out both sides of this form.

Section 1: Member's Current Information (as stated on prior Request for Confidential Communication):

Member Name_____
Address_____

City_____ State____ Zip_____

Phone Number (_____) - _____ Date of Birth _____Male ___ Female___

Relationship to Subscriber: Self ____Spouse ____ Child____ If other, describe type of relationship
_____

Section 2: Revocation or Revision of Prior Request:

Please indicate whether you want to revoke or revise your prior request for confidential communication.

- ❑ I would like to **revoke** my prior request for confidential communication.
  I understand that by revoking this request, EOBs relating to my care/treatment will be sent to the Subscriber and that any other written correspondence about my treatment/care will be sent to me at the Subscriber's address.
- ❑ I would like to **revise** my prior request for confidential communication and give UMR a new address and/or phone number.

If you are revising your prior request, please indicate the new address and/or phone number where you would like to receive all future communication from UMR about your health care:

Address _____

City_____ State____ Zip_____

Phone Number (_____)_____

Phone number where we can reach you if we have questions about this form: (_____)_____

Section 3: Signature of Member or His/Her Personal Representative

Authorized signature of the individual, or personal representative of the individual, for whom confidential communication is being requested:

I want UMR to communicate with me at the address or phone number, or in the manner requested, as listed above.

Signature of Individual:
X_____Date_____

Signature of Parent/Personal Representative (if applicable): X_____
Date_____

Parent/Representative's Name
_____Address_____

City_____ State ____Zip _____ Phone Number
(_____)_____

Relationship to individual and authority to act for individual
_____

Important: A personal representative, including a parent, legal guardian, or executor of an estate, may be required to attach a copy of legal documentation to this request form.

Section 4: Subscriber Identification (to ensure accurate processing)

Subscriber Identification Number_____Group Number_____

Employer_____

Subscriber Name_____

Address_____

City_____State_____Zip_____

Phone Number (_____)_____

PLEASE MAINTAIN A COPY OF THIS DOCUMENT FOR YOUR RECORDS

Please return the completed form to:

UMR
Customer Service Privacy Unit
PO Box 8006
Wausau WI 54402

Fax: 715-841-6195

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