AmeriHealth
ADMINISTRATORS

Request for Confidential Communications of Protected Health Information

PARTICIPANT PLEASE NOTE: THE PARTICIPANT MUST CLEARLY STATE THAT THE DISCLOSURE OF ALL OR PART OF THAT INFORMATION COULD ENDANGER THE PARTICIPANT. AMERIHEALTH ADMINISTRATORS IS NOT REQUIRED TO AGREE TO YOUR REQUEST. PLEASE SEE OUR NOTICE OF PRIVACY PRACTICES FOR MORE INFORMATION REGARDING SUCH REQUESTS.

Participant Name: _____ Date of Birth: _____

Participant Address: _____
Street Apartment # City, State Zip

Alternate Address: _____
Street Apartment # City, State Zip

Other Method of Contact: _____

Type of PHI to be redirected to the alternate address: _____

_____

_____

_____

_____

_____

_____ _____
Signature of Participant Date

FOR INTERNAL USE ONLY:

Date Request Received _____