Clover Health

Confidential Communications Request

Use this form to ask Clover Health to use alternative contact information, such as a phone number, mailing address, or email address, or another method(s) of contact, when we communicate with you about your Protected Health Information (PHI).

Section 1: Member Information	
Name:	
Date of Birth:	**Phone Number:**
Clover Member ID #:	

Section 2: Alternative Contact Information for Protected Health Information (PHI)

Please select one or more of the options below to request an alternative method for Clover Health to communicate with you about your Protected Health Information (PHI) safely and confidentially:

- ❑ I would like Clover Health to use the alternative telephone number below to communicate with me about PHI.
- ❑ I would like Clover Health to use the alternative mailing address below to communicate with me about PHI.
- ❑ I would like Clover Health to use the email address below to communicate with me about PHI.
- ❑ Other (Please be as specific as possible in the box below.)

Alternative Telephone Number:
Alternative Mailing Address (Including City, State, and Zip Code):
Email Address:
Other:

PLEASE FILL OUT THE REVERSE SIDE OF THIS FORM.

Will you or your privacy be at risk if we don't communicate with you about your PHI using the contact information you've provided on this form?

Section 3: Signature of Member or Authorized Representative

By signing this form, I understand that Clover Health will accept reasonable requests for confidential communications. I understand that once the request is received and approved, Clover Health will process my PHI according to my request. I also understand that I can cancel my request for confidential communications at any time in writing.

❑ Check here if you are signing as an authorized personal representative and provide your information below. Please attach the appropriate documentation (e.g., power of attorney, court order). Please note: the documentation must be validated by our Legal department before an authorized representative signature can be accepted.

Printed Name: _____

Relationship to Member: _____

Signature:	**Date:**

Please mail the completed form to:
Clover Health
P.O. Box 21164
Eagan, MN 55121

Or fax this form to:
Attn: Mailroom
1-866-508-0865