



REQUEST FOR CONFIDENTIAL OPTUM SPECIALTY PHARMACY COMMUNICATIONS AT AN ALTERNATIVE ADDRESS OR BY ANOTHER MEANS

Optum® Specialty Pharmacy occasionally provides you with confidential communications regarding the services you receive. You can use this form to request to have those communications redirected to a different address or distributed by a different method than usual. We will honor reasonable requests.

This form applies only to confidential communications from Optum Specialty Pharmacy.

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.

If your request is accepted, Optum Specialty Pharmacy will send written materials to the address you provide and/or call you at the alternative phone number you supply on this form. We will continue to do this until you tell us not to in writing.

To change or revoke your request, you must fill out a new form. If you move or want Optum Specialty Pharmacy to communicate confidentially with you at another address, you must complete and submit a new form. Requests to redirect confidential communications about services you receive from Optum Specialty Pharmacy cannot be made through your plan's usual enrollment process.

Optum Specialty Pharmacy will respond to requests submitted by your authorized representative, such as a parent, court-appointed representative or other family member, provided the representative is authorized by you to receive your protected health information (PHI). However, we may ask for more information from you or your authorized representative to verify the right to act on the your behalf.



REQUEST FOR CONFIDENTIAL OPTUM SPECIALTY PHARMACY COMMUNICATIONS AT AN ALTERNATIVE ADDRESS OR BY ANOTHER MEANS

Use this form to request that Optum Specialty Pharmacy communicate with you by another means or at a different address. When filling out this form, please complete all sections, print information clearly and provide your most current information.

1 Member information (please provide current information)

Last Name	First Name	MI
Mailing Street Address		Apt. #
City	State	ZIP
Date of Birth (mm/dd/yyyy)	Gender O M O F	Phone Number with Area Code

2 Alternative address or means

Please provide the address and/or phone number where you would like to receive future communications from Optum Specialty Pharmacy. The address must be different than the Subscriber's address or permanent address on record with Optum Specialty Pharmacy. If you provide an alternative address, Optum Specialty Pharmacy will send written communications to this address until you tell us in writing to use another.

Address	Apt. #
City	State
Phone Number with Area Code	ZIP

Please state the alternative means you would like Optum Specialty Pharmacy to use when communicating with you (if applicable):

3 Member/authorized representative signature

I want Optum Specialty Pharmacy to communicate with me at the address or phone number, or in the manner requested above.

X _____
Member Signature Date _____

X _____
Authorized Representative Signature (if applicable) Date _____

Important: If legal documentation is not on file with Optum Specialty Pharmacy, the authorized representative, including the parent, legal guardian, or executor of an estate, must attach a copy of legal documentation to this form.

Authorized Representative's Name	Phone Number with Area Code
Mailing Street Address	
Apt. #	
City	State
Relationship to Member and Authority to Act for Member	

4 Please mail the completed form to: Optum Specialty Pharmacy, Privacy Office, 2300 Main Street, Mail Stop: CA134-0304, Irvine, CA 92614

