meridianhealth

1 Campus Martius, Suite 700
Detroit, MI 48226

888-437-0606
TTY: 711
www.mhplan.com

Dear Member,

Inside is a Confidential Communications Request form which lets you request that we use different means or a different location when communicating with you. You or someone else has asked for this form on your behalf.

Below are steps for each section. You can use this as a checklist.

☐**SECTION 1: Your info**

☐**SECTION 2: Reason for request**

☐**SECTION 3: Location of contact**

☐**SECTION 4: Sign and date**

☐**SECTION 5: Return this form**

- All sections must be filled out or the form will not be processed
- This form does not take effect until Meridian receives it
- A response approving or denying your request will be sent to you within 30 days of us receiving this completed form
- We are only required to accommodate requests required by law

Please call Member Services at **888-437-0606** or email **privacy.mi@mhplan.com** if you have questions or need help filling out this form.

CONFIDENTIAL COMMUNICATIONS REQUEST

This form allows you to request that we communicate with you about all or part of your protected health information by alternative means or at an alternative location.

SECTION 1: YOUR INFO			
Name (First and Last):		**Date of Birth (MM/DD/YYYY):**	
Member ID#:		**Phone:**	
Address:	**City:**	**State:**	**Zip:**

SECTION 2: REASON FOR REQUEST

Please tell us why we should approve your request:

_____

_____

_____

SECTION 3: HOW TO CONTACT (CHOOSE ALL THAT APPLY)

What type of info: _____

_____

_____

Alternative means to contact for this info (select all that apply):

☐**Phone Number :** _____

☐**Email:** _____

☐**Alternate Address:**

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Special instructions for contact:

_____

_____

_____

_____

_____

_____

CONFIDENTIAL COMMUNICATIONS REQUEST

SECTION 4: SIGN AND DATE

Who is signing? ☐ Member listed above ☐ Parent of minor member listed above ☐ Someone other than member*

Signature: _____ **Date:** _____

Name (printed): _____

***Description of authority to act on behalf of the member (e.g. guardianship, durable power of attorney, court order, parent of minor child, etc.):** _____

You must attach the legal records shown above that name you as the representative of this member. There will be delays in this request if you do not give us this info.

SECTION 5: RETURN THE FORM

Send us a copy of this form by choosing one of the following:

1. **Fax this form to 313-324-9075**
2. **Email this form to privacy.mi@mhplan.com**
3. **Send this form by mail to the address below:**

MeridianHealth
Attn: Privacy Officer
1 Campus Martius, Suite 700
Detroit, MI 48226

meridianhealth

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888-437-0606
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MeridianHealth complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. MeridianHealth does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

MeridianHealth:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Meridian's Grievance Coordinator.

If you believe that MeridianHealth has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Meridian's Grievance Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Meridian's Grievance Coordinator is available to help you.

Mail:	MeridianHealth Attn: Grievance Coordinator P.O. Box 44287 Detroit, MI 48244
Telephone:	888-437-0606 (TTY users should call 711)
Fax:	313-463-5259
Email:	medicaidgrievances@mhplan.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

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Español (Spanish): ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 888-437-0606 (TTY: 711).

(Arabic): .(711 :888-437-0606)

繁體中文 (Chinese): 888-437-0606 (TTY: 711)

Tagalog (Tagalog-Filipino): PAUNAWA: Kung nagsasalita kayo ng Tagalog, maaari kayong gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 888-437-0606 (TTY: 711).

Ti ng Vi t (Vietnamese): CHÚ Ý: Nếu quý vị nói Tiếng Việt, chúng tôi có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 888-437-0606 (TTY: 711).

Deutsch (German): ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 888-437-0606 (TTY: 711).

(Korean) : , . 888-437-0606 (TTY: 711) .

: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 888-437-0606 (TTY: 711).

Italiano (Italian): ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 888-437-0606 (TTY: 711).

Polski (Polish): UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 888-437-0606 (TTY: 711).

Shqip (Albanian): KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 888-437-0606 (TTY: 711).

(Bengali) , 888-437-0606 (TTY: 711)

(Japanese): 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。888-437-0606 (TTY: 711) まで、お電話にてご連絡ください。

Srpsko-hrvatski (Serbo-Croatian): OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 888-437-0606 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 711)

(Assyrian): 888-437-0606 (TTY: 711)