



Confidential Communications Request Form

Use this form to request that Preferred Financial Group use an alternative means or an alternative location when communicating with you about your Protected Health Information (PHI). You have the right to request that we communicate with you about all or part of your PHI by alternative means or at an alternative location. We will accommodate your request if all of the following criteria are met:

1. The request is reasonable;
2. You clearly state that failure to honor your request could endanger you;
3. You provide reasonable alternative means or location for communicating with you, and;
4. You provide a satisfactory explanation how any payments (if applicable) will be handled using the alternative means or alternative location that you request.

To exercise this right, please complete this form. **If you need assistance in completing this form, please call the Customer Service number listed on the back of your Insurance Identification Card.**

When complete, return this form to:

**Privacy Coordinator
Preferred Financial Group Privacy Office
C/O Dental Network Of America
Two Trans Am Plaza Drive, Suite 500
Oakbrook Terrace, IL 60181**

Section A: The individual for whom communication by alternative means or at an alternative location is being requested. Please complete the following:				
Name		Group #	Identification\Subscriber #	
Social Security Number	Date of Birth			
Address	City	State	ZIP	
Area Code & Telephone Number	E-mail address (if available)		Country	

Section B: Please complete the following about the confidential communication request:	
Will the failure to communicate your PHI through alternative means or at an alternative location endanger you?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Please indicate the PHI that you would like to have communicated by alternative means or at an alternative location:	

I request that my PHI designated above be communicated by the alternative means or location listed below:	
<input type="checkbox"/> Mailing Address:	_____
<input type="checkbox"/> E-Mail Address:	_____
<input type="checkbox"/> Phone Number:	_____
<input type="checkbox"/> Fax Number:	_____

Section C: Signature.	
Signature of Individual or Individual's Personal Representative	Date: month/day/year

Section D: If Section C is signed by a Personal Representative, please complete the information below:			
Signature of Personal Representative		Relationship to Individual	
Personal Representative's Address	City	State	ZIP
Personal Representative's Area Code & Telephone Number	Personal Representative's E-mail address (if available)		Country