I. Your Protected Health Information
The Kentucky Employees’ Health Plan (“KEHP”) collects and maintains protected health information (“PHI”) that includes personal identifiers, enrollment, eligibility, and dependent and qualifying event information. KEHP utilizes a third-party claims administrator and a pharmacy benefits manager, referred to as “Business Associates,” to carry out certain functions for KEHP. Because of their administrative responsibilities, these Business Associates create, receive, maintain, and transmit PHI on behalf of KEHP. Like KEHP, the Business Associates are responsible for ensuring the protection of your health information.

Pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), KEHP and its Business Associates may use and disclose your PHI for treatment, payment, or health care operations including, but not limited to, claims processing, billing, case management, provider credentialing, and utilization review. Other uses and disclosures permitted or required by HIPAA are outlined in KEHP’s Notice of Privacy Practices.

II. Your Rights
You have the right to request to receive communications of PHI from KEHP by alternative means or at alternative locations (i.e. by e-mail, at home, at work). KEHP will accommodate reasonable requests to receive communications by alternative means or at alternative locations provided you clearly state, in writing:
- that the disclosure of all or part of your PHI could endanger you;
- how payment, if any, will be handled; and
- an alternate address or other method of contact.

III. Request for Alternative Communications

(a) Specify the types of communications regarding your PHI that are subject to your request:
___________________________________________________________________________
___________________________________________________________________________

(b) Specify the types of communication methods that are subject to your request.
(Check all that apply)

☐ E-mail  ☐ Mailing Address  ☐ Telephone  ☐ Other _________________

(c) Provide the alternative contact information:
- E-mail address: __________________________________________________________
- Mailing address:
  Street address/P.O. Box #: ______________________________________________
  City, State, and Zip: ______________________________________________________
- Telephone #: __________________________________________________________

If no alternative contact information is provided, KEHP will use the contact information on file.
Member Name: _________________________________
Planholder SSN:_________________ Date: __________
Member Relationship to Planholder ________________

(d) Could disclosure of all or part of the information to which the request pertains endanger you?
(Check one)
☐ Yes ☐ No

IV. Signature of Member or Member’s Personal Representative  *(Form MUST be completed before signing.)*

Printed Name of Member
___________________________________

Printed Name of Member’s Personal Representative (If Applicable)
___________________________________

Signature of Member or Member’s Personal Representative
___________________________________

If a Personal Representative – Describe Relationship to Member. Include authority/documentation proving status as a Personal Representative.
___________________________________

Date:_______________________________

Date:

Remit Form To: Sharron S. Burton, Privacy Officer
Office of Legal Services
Personnel Cabinet
501 High Street, 3rd Floor
Frankfort, KY 40601
Fax: (502) 564-7603
Sharron.Burton@ky.gov

V. KEHP Response to Your Request for Alternative Communications
KEHP will accommodate reasonable requests to receive communications by alternative means or at alternative locations. KEHP:

☐ Has changed your contact information and will contact you in the manner specified by your request.

☐ Has not changed your contact information in accordance with your request as you have not:
  ☐ Specified how payment will be handled (if applicable);
  ☐ Provided a valid alternative address or other contact information; or
  ☐ Affirmatively stated that disclosure of all or part of the information to which the request pertains could endanger you.

___________________________________  Date Received:_______________________________
Signature of KEHP Privacy Officer

Date Copy Mailed to Member: _____________________