A CENTRAL STATES HEALTH PLAN

ALTERNATE ADDRESS REQUEST

Use this form to designate an address other than the participant address that will be used for all explanation of benefits statements, correspondence, and claim checks*. If you would like to add a restriction to limit who can access your information, use the restriction form on the next page.*

Name of Participant Providing Health Coverage: ______________________

Participant's Identification Number: ______________________

Your Relationship to the Participant: ______________________

Your Name: ______________________

Your Address: ______________________

Your Phone Number: ______________________

Reason for Request: ☐ Custodial Parent ☐ Legal Separation ☐ Estate ☐ Adult Child

If this request is for child(ren), you must submit a legal document such as a copy of the divorce decree, child support order, or any other legal document that verifies custodial arrangements of the child(ren), if you have not already done so. **If Participant is providing primary insurance coverage, TeamCare requires approval and signature of the Participant to set up the alternate address for the child(ren) unless the relevant legal document not only provides for sole custody by the other parent, but also gives that parent sole authority to make medical decisions on behalf of the child(ren). This form will not waive or terminate parental rights of the Participant.** *A parent who does not have legal custody is always entitled to review a copy of any explanation of benefits (EOB) for his or her minor child(ren). However, requests to review an EOB will be denied when expressly prohibited by HIPAA laws and regulations.*

If the alternate address is on behalf of the estate of a deceased Participant or beneficiary, you must submit documents to establish that you have legal authority to act on behalf of the estate.

If the alternate address is on behalf of an adult child or spouse for themselves, the adult child or spouse should sign below. The signature of the Participant is not required.

Please list the child(rens) full name(s) and birthdate(s):

Name(s):	Birthdate(s):
Your Signature:	**Date:**
Participant Signature:	**Date:**

The completed and signed form can be submitted through the TeamCare message center at MyTeamCare.org, sent by fax to (847) 518-9789, emailed to PrivacyOfficer@centralstates.org, or mailed to:

Privacy Officer
TeamCare
PO Box 5125
Des Plaines IL 60017-5125

Please allow 3 to 5 business days to set up the alternate address. If you have any questions, the CustomerCare Center is available at 800-TEAMCARE.

REQUEST TO RESTRICT USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use this form If you would like to add a restriction to limit who can access your information. If you would like to designate an address other than the participant address that will be used for all explanation of benefits statements, correspondence, and claim checks, complete the form on the prior page.

Participant's Identification Number or Social Security Number: ______________________________

Participant's Name: ______________________________

Your Name (if you are not the Participant): ______________________________

Your relationship to the Participant (if you are not the Participant): ______________________________

Describe the restriction you would like placed on your health information and/or specify the password you would like added to your TeamCare record:

Effective date of your authorization: ______________________________

Expiration date of your authorization: ______________________________

Today's date: ____________________ Your signature: ______________________________

Print Name: ______________________________

TeamCare will make every attempt to comply with all reasonable requests for restrictions on the use and disclosure of your protected health information. If we are unable to comply with your request, you will be notified.

The completed and signed form can be submitted through the TeamCare message center at MyTeamCare.org, sent by fax to (847) 518-9789, emailed to PrivacyOfficer@centralstates.org, or mailed to:

Privacy Officer
TeamCare
PO Box 5125
Des Plaines IL 60017-5125