Request for Restriction of Information or Confidential Communications Form

Please Note: This form is used to request a restriction of your member information or provide an alternative address for confidential communication from WellSense Health Plan. Your information includes, but is not limited to, your medical claims, pharmacy claims, co-payments, case management information, vision claims and behavioral health claims. The Plan is not required to agree to a restriction request and may deny the request if it interferes with Plan operations or conflicts with federal or state law, rules and regulations. The record does not include medical records. You may request medical records directly from your medical providers. All fields are required. Incomplete or incorrect forms will be returned.

Member Information (Please print information clearly)			
Your member ID number (found on your WellSense Health Plan ID card)			
Member's last name			
First name	Middle initial		
Address	City	State	Zip code
Phone			

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WellSense HEALTH PLAN

Method to Receive Information

Please provide the Request Information to me in (please check the appropriate boxes).

☐ Electronic form;

☐ Paper form;

☐ Pick-up or view the Requested Information at a mutually agreeable time and place; OR

☐ Have the Requested Information mailed to me at the following address (if different than address above, write below).

Description of the information to be restricted (what type of information will be restricted?)

Check all boxes that apply:

☐ Designated Record Set **(includes enrollment, claims information, pharmacy utilization management, care management**	**From:**	**To:**
☐ Appeals Benefit Decision Documents	**Final Decision Date:**	
☐ Third Party Liability	**From:**	**To:**
☐ Member Services call log information	**From:**	**To:**
☐ Co-payment information	**From:**	**To:**

☐ Others (please list)

Purpose of Restriction: _____

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WellSense HEALTH PLAN

Request for Confidential Communication (person or organization that will receive your information – please note all mail will be sent to the address designated here)

I hereby authorize WellSense Health Plan to release my protected health information by mail to:

Person's name or organization:	Phone number:
Address	

I hereby authorize WellSense Health Plan to restrict the information requested above or direct all communications to the address provided.

Signature of Member/Personal Representative Date

WELLSENSE HEALTH PLAN USE ONLY	
Request received by:	Date (mm/dd/yyyy)

Mail or Fax Completed form to:

WellSense Health Plan

Attention: Member Services Dept.

100 City Square, Suite 200

Charlestown, MA 02129

Fax: 617-897-0884

Phone:

MA Health: 888-566-0010

Clarity plans: 855-833-8120

TTY: 711