M

Missouri Consolidated Health Care Plan

Request for Restriction on Use & Disclosure of Health Care Information and/or Confidential Communication
Public Entity Account

Submit this form

■Online: Upload through myMCHCP Fax:

Jefferson City, MO 65110-4355

 ⊕800-834-5181

 ⋈ Mail: PO Box 104355

PE RUD

Revised 04/2024

Address: New Address Social Security Number:							Revisea 04/2024
Section 1: Member Information Name (Last, First, MI):	Instructions						
Name (Last, First, MI): New Name MCHCP ID: OR	If you need assistance in cor	mpleting this form, plea	ase contact MCH	CP at 800-487-07	7 71.		
Address: New Address State: Zip Code: Primary Phone: Home Work Cell () - Secondary Phone: Home Work Cell () - Secondary Phone: Home Work Cell () - Secondary Phone: Cell () - Secondary Phone: Cell () - Secondary Phone: Home Work Cell () - Secondary Phon	Section 1: Member Info	ormation					
Address: New Address Social Security Number: Social Security Num	Name (Last, First, MI):	☐ New Name				MCHCP ID:	_
City: State: Zip Code: Primary Phone: Home Work Cell						OR	-
Secondary Phone: Home Work Cell () - Secondary Phone: Home Work Cell () - Section 2: Information Restriction and Confidential Communication Please fill out Column A and/or Column B: Column A Column B Health Care Information to be Restricted (Please specify what infor-mation Health Care Information to be Communicated Confidentially:	Address:	☐ New Address			Social Securit	y Number:	
Secondary Phone: Home Work Cell () - Secondary Phone: Home Work Cell () - Section 2: Information Restriction and Confidential Communication Please fill out Column A and/or Column B: Column A Column B Health Care Information to be Restricted (Please specify what infor-mation Health Care Information to be Communicated Confidentially:							
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Column A Column B Health Care Information to be Restricted (Please specify what infor-mation Health Care Information to be Communicated Confidentially:	Section 2: Information	Restriction and Con	nfidential Comn	nunication			
Health Care Information to be Restricted (Please specify what infor-mation Health Care Information to be Communicated Confidentially:	Please fill out Column A and	l/or Column B:					
	Column A					Column B	
should be restricted):	Health Care Information to be Restricted (Please specify what infor-mation				Health Care Information to	be Communicated Confide	entially:
	should be restricted):						
Nature of Restriction (Please specify to whom the information should be Preferred Alternative Location/Address/Telephone Number/Email:	Nature of Postriction (DI	assa spacify to whom	the information	should bo	Proformed Alternative Locati	ion/Address/Tolonhone N	umbor/Email:
restricted. Ex - health plan vendor, medical provider, relative, etc.):	-				Preferred Afternative Locat	ion/Address/ releptione iv	umber/Eman.
Section 3: Subscriber Authorization							
You have the right to request that we restrict our use and disclosure of your health care records and information. We do not have to agree to your requested restrictions. If we do agree to the requested restriction, we will abide by the restriction unless an emergency requires otherwise. You also have the right to request				•			
that we communicate certain health care information to you in confidence. We will accommodate your rea-sonable written requests to receive communications of							
health information by alternative means or at alternative locations only if you specify the alternative location, address, or telephone number and/or the alternative	health information by altern		•				
	means of contact.						
Signature of Member: Date (MM/DD/YYYY):	Signature of Member:					Date (MM/DD/YYYY):	,
	Or, Signature of Person Authorized by Law to Act for the Member (Attach proof of authority to act):						
Or, Signature of Person Authorized by Law to Act for the Member (Attach proof of authority to act): Date (MM/DD/YYYY):						Date (MM/DD/YYYY):	,
						/	
MCHCP STAFF ONLY	MCHCP STAFF ONLY						
Reason for Restriciton: Accepted Denied Request to Communicate Confidentially: Accepted Denied	Reason for Restriciton:	☐ Accepted	☐ Denied	Request to C	ommunicate Confidentially:	☐ Accepted	☐ Denied

This Request for Restriction and/or Confidential Communication Form is to be made a part of the medical record of (Member Name):