Insert Date:
Notice Type (check one below)
☐ **New Non-Disclosure Agreement**
☐ **Extended Expiration Date of Non-Disclosure**
☐ **Withdrawal of Non-Disclosure Agreement**

NOTICE OF NON-DISCLOSURE OF MINOR-INITIATED MENTAL HEALTH CARE FOR HEALTH PLANS

Insurance Plan: _____ **Phone #**: _____

Insurance Type: ☐ Medicaid ☐ Medicare DSNP

Provider's Name: _____
(Last Name) (First Name) (Middle Initial)

Minor's Name: _____
(Last Name) (First Name) (Middle Initial)

Minor's Address:

_____

Minor's Date of Birth: _____ **Minor's Health Plan ID:** _____
Member ID #: _____ **Group Number:** _____

Mother's Name: _____
or Legal Guardian (Last Name) (First Name) (Middle Initial)

Father's Name:
or Legal Guardian _____
(Last Name) (First Name) (Middle Initial)

Pursuant to §577-29, HRS, minors, 14 years of age or older, may consent to outpatient mental health services without parental or legal guardian consent, knowledge or participation, after consulting with a licensed mental health professional and there is agreement on confidentiality for minor initiated services.

Attached is a signed agreement that states the minor received mental health counseling which included a discussion on confidentiality, and the minor and the licensed mental health professional agree that the minor's mental health services should not be disclosed to the minor's parents/legal guardian for the period of time specified in the agreement.

_____ is hereby notifying the minor's health plan that the minor's self-initiated mental health services should not be disclosed to the minor's parent(s)/legal guardian through the health plan's explanation of benefits or by any other means. Non-disclosure is temporary and begins according to the effective date in the agreement with the minor. Should the non-disclosure agreement be withdrawn, or should the nondisclosure be extended, the mental health provider will notify the health plan with an updated agreement.

ATTACH THIS NOTICE TO THE NON-DISCLOSURE AGREEMENT BEFORE SENDING THE FORMS TO THE APPROPRIATE HEALTH PLAN

NON-DISCLOSURE OF MINOR-INITIATED MENTAL HEALTH CARE AGREEMENT

Pursuant to §577-29(a), HRS, minors, 14 years of age or older, may consent to outpatient mental health services without parental or legal guardian consent, knowledge or participation, after a licensed mental health professional determines that the minor is mature enough to participate intelligently in the mental health treatment or counseling services. Here is an agreement on confidentiality for minor-initiated services.

Minor's Statement:

I am a minor and am 14 years of age or older. I am seeking mental health services without consent, knowledge or participation of my parent/legal guardian. My licensed mental health care provider and I had a discussion and there was agreement, that it is in my best interests not to involve my parents in my mental health treatment or counseling services, at this time. I am requesting confidentiality of my minor-initiated mental health service information and that this information not be disclosed to my parent(s)/legal guardian through my health plan's explanation of benefits or by any other means. I understand that I or my therapist may withdraw this agreement and this agreement is temporary as specified by my therapist.

Minor's Signature REQUIRED:

_____ Date: _____

Printed Name: _____ Date of birth: _____

Licensed Mental Health Professional's Signature REQUIRED:

_____ Date: _____

Printed Name: _____ Date of birth: _____

Agency or name of business: _____

Name of Mental Health Professional who conducted the client's "minor-initiated" initial assessment (if applicable): _____

To be completed and dates initialed by the minor's therapist	
Nondisclosure Effective Start Date:	**Nondisclosure Expiration Date:**
Extension of Nondisclosure Start Date:	**Extension of Nondisclosure Expiration Date:**
Agreement Withdrawal Date:	

Note: This Privacy Agreement will not expire unless a Non-disclosure withdrawal is submitted.

PROVIDER NOTICE:

In addition to this form:

1. This non-disclosure agreement applies only to this listed Provider & Member relationship.

2. Is the Provider In-Network with United Behavioral Health? ☐ Yes ☐ No
   - If No, providers are required to obtain an authorization for these services. The "HI Behavioral Health Prior Auth Request Form" can be found on the Hawaii page of providerexpress.com.

3. If the Provider is NOT In-Network, and the provider wants to utilize non-credentialed mental health clinicians for these services, then a Supervisory Protocol Agreement is **required.**
   - Please indicate here.☐ **Yes,** I plan to use non-credentialed mental health clinicians.
   - **Note:** This Supervisory Protocol Agreement must be in place before any non-credentialed mental health services are offered.

4. In-Network providers are **required** to have a Supervisory Protocol Addendum (Addendum to the Group Participation Agreement) added to their provider contract if provider chooses to utilize non-credentialed mental health clinicians for these services.
   i. **Note:** This Supervisory Protocol Addendum must be in place before any non-credentialed mental health services are offered.
   ii. Please submit an email request to the following email to obtain a copy of the form of Addendum. westbhcontracting@optum.com

5. Is the Provider an FQHC? ☐ Yes ☐ No
   iii. FQHC – Services rendered utilizing Supervisory Protocol may be reimbursed at the encounter rate only if the service was rendered during (on the same day) as a qualified "core visit".

Provider **MUST** include, in addition to Licensed Provider Name: All potential Phone #'s, NPI's, Provider ID's, Tax ID's, Service & Billing addresses associated with this Member's care:

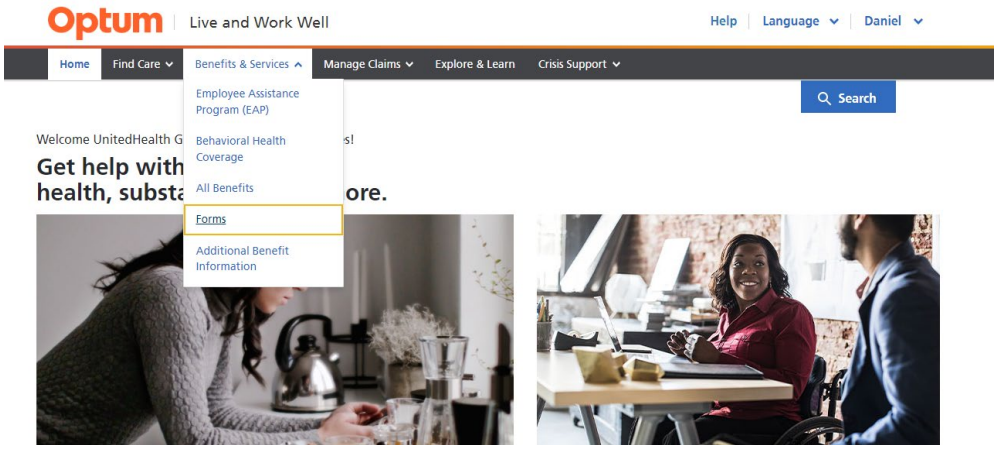
Provider Name	Phone #	NPI	Provider ID	TAX ID	Service Address	Billing Address

Please return this completed form via facsimile at this number: 1-877-840-5581.

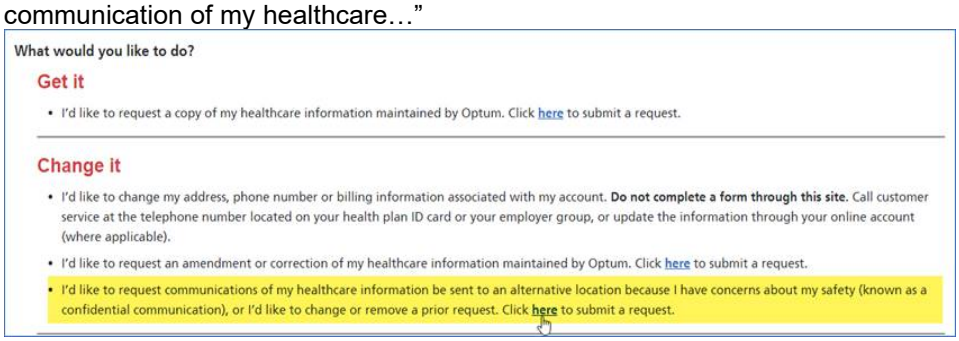
IMPORTANT INFORMATION THE PROVIDER MUST SHARE WITH MEMBER AND ASSIST THE MEMBER IN TAKING THE FOLLOWING ACTIONS.

Please provide Member with a copy of these instructions.

1. Member **MUST TAKE ACTION** and sign up for the Confidential Communications process and provide an address to use. Member can provide an alternate address or member's home mailing address (even if it is the same as the parent's address). Any claim Explanation of Benefits (EOB's) will be mailed to the address provided (unless member's communication preferences are changed from mail to email – See Step 2).
    i. To make verbal request: Member must call customer service at the telephone number located on member's health plan Medical ID card. State member would like to setup "Confidential Communications" and, the member must provide an address to use. If the member has an Alternate address, provide that address, if member does not have an alternate address, member must provide member's home mailing address (even if it is the same as the parent's address).
    ii. To make online request: Sign in to www.liveandworkwell.com. If member does not already have an account, member must create a new account (See Below on how to create a HealthSafe ID (HSID) login/account on Myuhc.com)
        a. Note: If member has an existing account with an HSID login, member can use this same HSID to login as an existing member on liveandworkwell.com.
        b. Navigate to "Benefits & Services", from the drop-down, choose "Forms"



        c. Under Forms, scroll down to select "Managing your Healthcare Information"
        d. Under "Change it", select the form shown in yellow below for "I'd like to request communication of my healthcare…"



        e. Member MUST include an address for this process to work. Either an alternate address or member's Home Address (even if it is the same as the parent's address).
            i. The member can change member's communication preferences from mailing to email in Step 2 below.

f. Fill out the form and submit to the Fax number or mail to the address provided on the form.
    i. Note: Section 6 of the form is only to receive a response for the form being submitted. Member must still update member's communication preferences if member would like to change from sending correspondence via mail to email.

2. If member does not have an alternate address and does not want correspondence mailed to them, member can create an account with member's own login on Myuhc.com to obtain member's HSID login. Member can then change their "Communication Preferences" for EOBs from paper (mail) to electronic (email) by following the instructions below.
    a. <u>Note:</u>
        i. If the Parent/Subscriber has already created an account in the minor member's name, the minor member will not be able to setup member's own account. If this happens, the minor member must call the customer service number on the back of member's medical ID card and ask customer service to help member setup member's HSID login for Myuhc.com. Ask customer service to help update/change the login and username that is currently setup on member's account to member's name and member's password.
        ii. If an alternate address is not provided, correspondence will be mailed to the address of record, addressed to the minor, or EOB's will be emailed if the communication preferences are changed.

    b. Instructions to change member's communication preferences on Myuhc.com are:
        i. Go to member's "Account/Profile", then "Account Settings". In "Account Preferences" member can update "Communication and Mailing Preferences" then "Paperless Settings for Required Communications" and update to "Paperless" by providing member's email address.