HIPAA Designation Form

for groups with 10 or more employees

BlueCross BlueShield of Kansas

bcbsks.com

Group Name

Group Number

Section 1 – Plan Sponsor Information

CLEAR DATA

Plan Sponsor: A legal entity that offers the Group Health Plan (GHP) to its employees or members.

Plan Sponsor Representative: May be a director, senior executive, and all other applicable employees who do not require access to enrollees' Protected Health Information (PHI) to perform their day-to-day job functions. These individuals should have no access to the employees' PHI other than their own personal information.

Plan Sponsor (Business Name)

Plan Sponsor Representative Name

Title

Business Mailing Address of Plan Sponsor Representative

(_____) _____-_____
Phone Number

(_____) _____-_____
Fax Number

City

Email Address

State ZIP Code +4

Section 2 – Plan Administrator Information

Plan Administrator: The entity responsible for many of the administrative and fiduciary duties imposed by ERISA and HIPAA as designated by a plan's governing documents. If the Plan Administrator is not designated, then the Plan Sponsor (commonly the employer) is the Plan Administrator.

Plan Administrator Representative: An individual within an employer group designated to act on behalf of the Plan Administrator.

Applicable to ASO groups only – The person(s) named in this section is the only person(s) in the group who can have access to PHI.

Plan Administrator (Business Name)

Plan Administrator Representative Name

Title

Business Mailing Address of Plan Administrator Representative

(_____) _____-_____
Phone Number

(_____) _____-_____
Fax Number

City

Email Address

State ZIP Code +4

Section 3 – Group Leader Information

Group Leader: A term not defined in HIPAA Privacy Rules, but means the person whom the Plan Sponsor designates to handle enrollment and disenrollment of GHP members. This person should have no access to the employees' PHI.

Group Leader Name

Title

Business Mailing Address of Group Leader

(_____) _____-_____
Phone Number

(_____) _____-_____
Fax Number

City

Email Address

State ZIP Code +4

Please continue on the next page.

Section 4 – Privacy Officer Information (only applicable to ASO/OHCA groups)

Privacy Officer: The person responsible for the development and implementation of policies and procedures necessary for HIPAA compliance.

Do you have a Privacy Officer? ☐ Yes ☐ No (If yes, complete the following information about your Privacy Officer.)

Privacy Officer Name

Title

Business Mailing Address of Privacy Officer

(_____) _____-_____
Phone Number

(_____) _____-_____
Fax Number

City

Email Address

State ZIP Code +4

Section 5 – Secondary Contacts

To include additional Plan Sponsor Representatives, Plan Administrator Representatives, Group Leaders or Privacy Officers, please complete the information in this section.

☐ Plan Sponsor Representative ☐ Plan Administrator Representative ☐ Group Leader ☐ Privacy Officer

Name

Title

Business Mailing Address

(_____) _____-_____
Phone Number

(_____) _____-_____
Fax Number

City

Email Address

State ZIP Code +4

☐ Plan Sponsor Representative ☐ Plan Administrator Representative ☐ Group Leader ☐ Privacy Officer

Name

Title

Business Mailing Address

(_____) _____-_____
Phone Number

(_____) _____-_____
Fax Number

City

Email Address

State ZIP Code +4

Section 6 – Important Notes

1. Changes to Section 1 may only be made by the current Plan Sponsor Representative or an officer of the company.
2. Changes to Sections 2 and 3 may only be made by the current Plan Sponsor Representative, Plan Administrator Representative or an officer of the company.
3. When making changes or adding contacts in Section 4, follow the guidelines as stated in Important Notes 1 and 2.

By signing below, I certify that I am authorized, as Plan Sponsor Representative, Plan Administrator Representative or an officer of the company, by the employer group named above and its group health plan to assign and/or affirm the designation of the individual(s) named on this form.

Your signature required

Applicant

_____ /_____ /_____
Date Signed

Print Name

Title