HIPAA Designation Form

BlueCross BlueShield Kansas

Group Name | Group Number/MPN | Category

Please route to the following (check all that apply): ☐ Blue Cross and Blue Shield of Kansas ☐ Advance Insurance Company of Kansas

Section 1 – Group Information

CLEAR DATA

_____ /_____ /_____
Effective Date of Change

NOTE: If you have changes to contact types in multiple categories, please send a form for each category.

☐ New group
☐ Existing Group – Update current contact information listed within sections 2 through 8.
☐ Existing Group – Leave all existing contacts as is and add the contacts listed within sections 2 through 8.
☐ Existing Group – Remove all existing contacts and replace with the contacts listed within sections 2 through 8.
☐ Existing Group – Remove the following contacts from the selected contact type and add the contacts listed within sections 2 through 8.

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

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

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

Section 2 – Plan Sponsor Information

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) | Title

Plan Sponsor Representative Name | (_____) _____-_____ Phone Number | (_____) _____-_____ Fax Number

Business Mailing Address of Plan Sponsor Representative | Email Address

City

This person is granted access to information for electronic enrollment and eBilling (email address required). ☐ Yes ☐ No

State | ZIP Code | +4

Please continue on the next page.

Section 3 – 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, the Plan Sponsor (commonly the employer) must be listed as 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)

Title

Plan Administrator Representative Name

(_____) _____-_____ Phone Number

(_____) _____-_____ Fax Number

Business Mailing Address of Plan Administrator Representative

Email Address

City

This person is granted access to information for electronic enrollment and eBilling (email address required). ☐ Yes ☐ No

State ZIP Code +4

Section 4 – 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. This person is granted access to information for electronic enrollment and eBilling (email address is required).

Group Leader Name

Title

Business Mailing Address of Group Leader

(_____) _____-_____ Phone Number

(_____) _____-_____ Fax Number

City

Email Address

State ZIP Code +4

Section 5 – 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.

ASO/OHCA groups are required by HIPAA to designate a Privacy Officer. Blue Cross and Blue Shield of Kansas will consider the Plan Administrator to be the Privacy Officer unless other information is provided.

Privacy Officer Name

Title

Business Mailing Address of Privacy Officer

(_____) _____-_____ Phone Number

(_____) _____-_____ Fax Number

City

Email Address

State ZIP Code +4

Please continue on the next page.

Section 6 – Secondary Contacts

To include additional Plan Sponsor Representatives, Plan Administrator Representatives, Group Leaders or Privacy Officers, please complete the information in this section. **Please note**: Group Leaders will automatically have access to eBilling (email address required).

☐ 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 _____

This person is granted access to electronic enrollment and eBilling (email address required): ☐ Yes ☐ No

☐ 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 _____

This person is granted access to electronic enrollment and eBilling (email address required): ☐ Yes ☐ No

Section 7 – Party to Receive Correspondence (PTRC)

Who is the party to receive correspondence? (This person must be listed on this form or must be an existing contact. Only one PTRC can be listed per category/segment.)

Section 8 – Billing Contact

Who is the party to receive correspondence and billing inquiries? (This person will receive electronic and/or billing notifications. This person must be listed on this form or must be listed per category/segment. Only one billing contact can be listed per category.)

Section 9 – Important Notes and Authorization

1. Changes to Section 2 may only be made by the current Plan Sponsor Representative or an officer of the company.
2. Changes to Sections 3 through 8 may only be made by the current Plan Sponsor Representative, Plan Administrator Representative or an officer of the company.

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 _____

Internal Use Only – Routing

Please route to **Membership.Assistance@bcbsks.com** and **CSC-Advance@bcbsks.com** as indicated in Section 1.