# HIPAA Designation Form

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

_____ /_____ /________
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 7.
☐ Existing Group – Leave all existing contacts as is and add the contacts listed within sections 2 through 7.
☐ Existing Group – Remove all existing contacts and replace with the contacts listed within sections 2 through 7.
☐ Existing Group – Remove the following contacts from the selected contact type and add the contacts listed within sections 2 through 7.

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 – 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 7 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.