DESIGNATED CONTACT PERSON(S)

In accordance with §164.504(f)(2)(iii)(B) of the HIPAA Privacy Rule, please designate the person(s) in group health plan administration who is able to receive protected health information (PHI).

Notes: This form must be completed by someone with proper authority within your organization (for example, the Privacy Officer). We ***require names, not merely job titles, of individuals who may receive PHI.***

Please complete a new form whenever there is a change to the Designated Contact Person list.

☐ ADDITION of contact person

☐ CHANGE / DELETION of contact person (please indicate next to name)

Broker Contacts (see below)

☐ Check this box if your group wants to name a BROKER as a Designated Contact Person.

COMPANY NAME:_____**GROUP #** _____

Name:	Name:
Title:	Title:
Address:	Address:
City, State, Zip:	City, State, Zip:
Phone:	Phone:
Fax:	Fax:
Email:	Email:

Certification of Plan Sponsor of group dental plan who is giving final approval to any <u>additions</u>, <u>deletions</u> or <u>modifications</u> to the information that is currently on file as a result of the submittal of new information included on this form.

_____ _____
Signature Title

_____ _____
Print Name Date

_____
E-mail address

DESIGNATED CONTACT FOR BILLING

Name of person to receive weekly Claims Detail Summary Reports:_____
(Please provide contact information if not provided in chart above).

Please return this form to: Delta Dental of Minnesota
Attn: Account Management
500 Washington Avenue South, Suite 2060
Minneapolis, MN 55415

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