

Authorization Form Granting Access to PHI - Insured Client Instruction Sheet

The purpose of this form is for insured clients to officially name individuals within the group that both control the flow of benefit related data for the organization and who can have access to said data. This sheet is to serve as a guide to the attached form titled "Authorization Form Granting Access to PHI - Insured Clients". *Note – Insured clients may only access Enrollment and summary level claims information. Individual level claims information requires an authorization from each individual.*

Re: Sponsor Name _____
 Group Dental Plan Name _____
 Group Dental Plan Number(s) _____

← This section of the form should indicate the sponsor name, group name and group number. Group number may be sub-location specific. A separate form should be completed if access rights differ by sub-location. Please complete this information on BOTH pages 1 & 2 in case pages become separated.

B. The following individual(s) and/or job titles are duly authorized to identify to You those persons or entities whom the Sponsor has authorized to receive protected health information on its behalf (These persons have the Sponsor's authorization to inform You as to who should be able to access and/or receive PHI):

Name	Address	Title

← This section should name the associate that will control the flow of benefit related information. In many cases this is the Benefits Administrator or the vice president of Human Resources.

C. The following individual(s) and/or job titles are duly authorized to receive protected health information (as defined in the Privacy Rule) from You. The persons named will be able access and receive the following PHI:

VDE = View Dental Enrollment/Dis-Enrollment/Participation Status (check if applicable)
SHI = Summary Health Information (as defined in 45 Code of Federal Regulations § 164.504(a) (check if applicable))

Name	Company	Title	Telephone #	Fax #	VDE	SHI

← This section should name the associates and/or third parties that should have access to the benefits information. Examples of these individuals may be internal human resource associates, brokers, third party administrators, etc. The same associate named in section B could also be listed in section C as well. This is the case for many clients. You must also indicate level of access here as VDE or SHI.

D. The following individual(s) and/or job titles are duly authorized to add, modify and/or delete enrollment information (i.e. electronic data files, on-line enrollment, etc.) on behalf of the Group Dental Plan:

Name	Co. Name	Address	Role (e.g. third party administrator, broker)

← This section should name the associates and/or third parties that should have access to enrollment information. This area would be utilized to name associates, brokers or third party administrators that utilize our online eligibility updates or transmit electronic eligibility to Delta Dental. The same associate(s) named in section C could also be listed in section D as well.

(Plan Sponsor's Name)

By: _____
 (Signature)

Print Name: _____

Title: _____

Effective Date: _____

← ****All forms must be filled out in completion and signed and dated in the final section. The form must be mailed with an original signature (faxes not accepted) to:**
Delta Dental of New Jersey, Inc.
Attn: Client Support
1639 Route 10
Parsippany, NJ 07054