

## Authorization Form Granting Access to PHI - Self Funded Client Instruction Sheet

The purpose of this form is for self-funded 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 - Self Funded Client".

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):

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

Name	Address	Title

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. These persons will be able access and receive PHI relating to the Group Dental Plan.

← 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, benefit consultants, 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 groups.

Name	Co. Name	Title	Telephone #	Fax #

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:

← 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, benefit consultants 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.

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

(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**