BlueCross BlueShield of Alabama

An independent licensee of the Blue Cross Blue Shield Association

Company Name:	
Group Number(s):	

DESIGNATION OF BUSINESS ASSOCIATE OF INSURED GROUP HEALTH PLAN

To comply with HIPAA Privacy Rules, please complete this form to give us the names of other Business Associates of your Group Health Plan (such as, third party administrators, benefit consultants or pharmacy benefit managers) to whom you (on behalf of the Group Health Plan) want us to disclose Protected Health Information (PHI). Also list any conditions or limitations that apply to our disclosure, and indicate if this Business Associate is only authorized to receive PHI on a segment of the Group Health Plan (for example, COBRA only, Dental only, etc). Without your authorization, we will not disclose PHI to the Designated Business Associate of your Group Health Plan.

The undersigned Group Health Plan hereby certifies, represents and warrants to Blue Cross and Blue Shield of Alabama that the company listed below is a Designated Business Associate.

A Designated Business Associate of the group health plan has entered into a Business Associate Agreement with the Group Health Plan that both:

(a) Permits the designated company to request and receive (on behalf of the Group Health Plan) the Protected Health Information (PHI) that Blue Cross and Blue Shield of Alabama maintains with respect to the Group Health Plan, and

(b) Complies with the privacy provisions of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations.

The Group Health Plan hereby requests Blue Cross and Blue Shield of Alabama to disclose such Protected Health Information (PHI) to the Business Associate (on behalf of the Group Health Plan), as the Business Associate may request from time to time, at the location and contact information set forth below.

The Group Health Plan agrees to notify Blue Cross and Blue Shield of Alabama immediately if any representations or warranties herein change.

Executed this:	Day of	Year	

For the Plan(s):

Group Health Plan *(Print Company Name)*	**Group Number(s)**

Signed:	**Printed/eSignature:**
Title:	

Note: *Form must be signed by the group Decision Maker on file with Blue Cross and Blue Shield of Alabama.*

BUSINESS ASSOCIATE INFORMATION *(To be completed by the Group Health Plan):*

Company Name	Condition/Limitation/Segment

The release of protected health information to the Group Health Plan's Business Associate(s) identified above is limited to Enrollment/Eligibility, Billing and Collection Data, and Summary Information.

Please complete, sign and return this form to:

Blue Cross and Blue Shield of Alabama
Attention: Enrollment Services
Fax: 205-220-9902 or Email your designated Enrollment Service Representative.