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)

COMPANY NAME: ____ **GROUP #** _______

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

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

Return form to: Delta Dental of Minnesota
Attn: Sales & Marketing
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