Sanford Health Plan Privacy Authorization Form

(for provider entity completion)

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SANFORD HEALTH PLAN

Authorization for Use or Disclosure of Contractual and Protected Health Information (Required by the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 and 164, and Health Information Technology for Economic and Clinical Health (HITECH) Act 42 CFR Parts 412, 413, 422 and 495). Sanford Health Plan shall not disclose any information including, but not limited to: member eligibility & benefits, reimbursement rates, fee schedule, reimbursement methodologies, appeals, pre-authorization, pharmacy information to any third party without written consent from legal representative of the Provider. In order to release information, Sanford Health Plan must first receive and approve the completed Sanford Health Plan Privacy Authorization Form. An authorized Sanford Health Plan representative will validate the information received.

Return the completed form to:
Sanford Health Plan Provider Relations at providerrelations@sanfordhealth.org or fax: (605) 328-7224.

Provider Entity Information		
Provider (Name as it appears on contract or W9 form)	Tax ID	Primary Address
Legal representative contact name	Phone Number	Email Address

Third Party Information		
Name of Third Party Company	Third Party Contact Name	Address
Phone Number	Contact Email Address	Third Party Company Website
THIRD PARTY COMPANY DOES NOT SEND DATA OFFSHORE		

1. Authorization
I authorize Sanford Health Plan to use and disclose the protected written or verbal information described above to_____ (Third Party Company). I understand my authorization shall effective for the period as defined in section 2 (Effective Period) of this form and that the information shall be handled confidentially in compliance with all applicable Federal and state laws and administrative rules.

2. Effective Period
This authorization shall be in force beginning _____ (MM/DD/YYYY) and effective until _____, (MM/DD/YYYY) at which time this authorization expires. If no date is noted, this authorization shall expire one year from the date of signature unless Sanford Health Plan is informed of an earlier date.

3. Extent of Authorization
I authorize the release of the following information, including but not limited to: affiliated member eligibility & benefits, claims, reimbursement rates, fee schedule, reimbursement methodologies, check information, appeals/ claim reconsiderations, pre-authorization, pharmacy information.

4. This information may be used by the person and/or company I authorize to receive this information for billing or claims payment, or other purposes as I may direct.

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5. I understand I have the right to revoke this authorization, in writing, at any time by providing written notice to Sanford Health Plan Attn: Provider Relations.

6. I understand a revocation is not effective to the extent any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insured has a legal right to contest a claim.

7. I understand information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

8. I further understand this authorization is voluntary and I may refuse to sign this authorization.

9. Provider agrees that, consistent with paragraph 2 (e) of its Business Associate agreement with Sanford Health Plan, it has an agreement with the third party, identified on this authorization, to share data with restrictions.

By signing this form, I represent I am the legal representative of the Provider identified above and provide written proof that I am legally authorized to act on the Provider's behalf with respect to this authorization form. I agree to release and hold harmless Sanford Health Plan from any claims of action or damages arising from, or connected to, the release or use of any information pursuant to this Release of Authorization.

I further certify that no data being transmitted by this authorization is being sent offshore, outside the boundaries of the United States.

Printed Name of Legal Representative:_____

Signature of Legal Representative: _____

Title:_____

Date: _____ Phone Number: _____

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