



# HIPAA CERTIFICATION

The signature below certifies that the Plan Sponsor has amended its plan document to include the provisions specified in §164.504(f)(2) of the HIPAA Privacy Rule and will abide by such provisions.

Signature of Privacy Officer: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

## 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):

- NEW      As of (date): \_\_\_\_\_
- CHANGE      As of (date): \_\_\_\_\_

Name:	Name:
Title:	Title:
Address:	Address:
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 Nebraska  
                                 Attn: Privacy Officer  
                                 P.O. Box 9304  
                                 Mpls., MN 55440-9304