



**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 just 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)

**Broker Contacts (see below)**

- Check this box if your group wants to name a BROKER as a Designated Contact Person.

COMPANY NAME: \_\_\_\_\_ GROUP # \_\_\_\_\_

Name:	Name:
Title:	Title:
Address:	Address:
City, State, Zip	City, State, Zip
Phone:	Phone:
Fax	Fax:
E mail	E mail

**Signature of Privacy Officer of group dental plan who is giving final approval to any additions, deletions or modifications to the information that is currently on file as a result of the submittal of new information included on this form.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Title

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
E-mail address

**DESIGNATED CONTACT FOR BILLING:** 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  
500 Washington Ave South, Suite 2060  
Minneapolis, MN 55415