



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: _____

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:
Address:	Address:
Phone:	Phone:
Email:	Email:

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 North Carolina
343 E. Six Forks Road, Suite 180
Raleigh, NC 27609
Fax # (919) 832-6549