Business Associate Documentation

Please complete this form in order for Tufts Health Plan to disclose, or discontinue disclosure of, Protected Health Information (PHI), as defined in 45 C.F.R. 160.103, for the purpose of Plan Administration Functions, as defined in 45 C.F.R. 164.504, to the Business Associate of the group named below.

Please check (☑) below whether you are:

☐ adding the following business associate; or

☐ deleting the following business associate

If your intent is to replace one business associate (BA) with another, please note that you must complete separate forms for each transaction. If we do not receive a form removing a BA, we will continue to provide PHI to BAs previously listed on all other documentation provided to Tufts Health Plan.

Name of Group: _____

Tufts Health Plan Group Number: _____

Account Manager: _____

Name of Business Associate: (please use business name when applicable) _____

Business Associate's Phone Number: _____

When adding a Business Associate, please review and sign below:

I hereby represent and warrant the following:

- the Business Associate named above has entered into a valid business associate agreement, as required by 45 C.F.R. 164.504 with the group health plan as defined in 45 C.F.R. 160.103;
- that the requested disclosure shall comply with all applicable privacy and data security provisions of 45 C.F.R. Part 164,
- the business associate agreement prohibits the Business Associate from disclosing PHI to the Plan Sponsor, except as permitted by the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated thereunder; and
- I am authorized to sign this representation on behalf of the group listed above.

_____ _____

Signature Date

Title _____

Fax or mail your signed and completed form to your Tufts HP sales or account representative.