

## **Business Associate Accounting for Disclosures Report Form**

Individuals have the right to an accounting of certain disclosures Blue Cross Blue Shield of Minnesota (Blue Cross) and our business associates make of their protected health information within the six years prior to their request. Blue Cross will fulfill these requests by producing a member disclosure summary.

Business associates will follow the specific guidelines outlined below to forward required disclosures to Blue Cross, which will then to be added to our accounting for disclosure database.

### **When to Use this Form**

If a disclosure is subject to an accounting, business associates must use this form to record the disclosure information.

**PLEASE NOTE:** Not all disclosures of an individual's protected health information are subject to an accounting. Please review the enclosed ***Disclosure Accounting Matrix*** form, which provides a comprehensive list of disclosures and their respective accounting requirements.

Business associates are not required to account for disclosures they made:

- ◆ Before the Privacy Rules compliance date (4/14/03)
- ◆ To the individual
- ◆ To or for notification of persons involved in an individual's care
- ◆ For treatment, payment, or health care operations
- ◆ For national security or intelligence purposes
- ◆ To correctional institutions or law enforcement officials regarding inmates
- ◆ For research if the research involves at least 50 records and we provide individuals with a list of all the research protocols and the researcher's name and contact information
- ◆ Using de-identified health information.

The law does not require you to account for the above disclosures.

Submit this form to Blue Cross within one month after making a required disclosure.

Disclosure of multiple members to the same entity - each member's disclosure will be accounted for individually. Please use a separate form for each disclosure.

### **Mail this Form to**

Blue Cross and Blue Shield of Minnesota and Blue Plus  
Attention: Compliance and Regulatory Affairs  
P.O. Box 64560  
St. Paul MN 55164-0560

Disclosure means the release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

DISCLOSURE	ACCOUNTING REQUIRED	ACCOUNTING <b>NOT</b> REQUIRED
<u><i>Covered entities <b>must</b> disclose PHI:</i></u>		
➤ To the individual		X
➤ To the Secretary of HHS for compliance investigation purposes	X	
<u><i>Covered entities <b>may</b> disclose PHI:</i></u>		
➤ For treatment, payment, and healthcare operations (TPO) purposes		X
➤ With authorization of the individual		X
➤ To Parents and Personal Representatives		X
➤ To Business Associates for other than TPO	X	
➤ To Affiliates for other than TPO	X	
➤ Pursuant to a verbal agreement after individual has been given the opportunity to agree or object (e.g. facilities directory, next of kin, person involved in individual's care or for notification or emergency situations)		X
➤ Without consent or authorization if:		
• required by law if: related to child abuse, neglect, or domestic violence; in the course of judicial and administrative proceedings; or for law enforcement purposes	X	
• for public health activities including disclosures for the purpose of preventing or controlling disease and disclosures related to victims of child abuse or neglect	X	
• adult abuse, neglect and domestic violence	X	
• health oversight - disclosures do not have to list each specific disclosure in the individual's file but must show that the public health authority had access to the files	X	
• judicial and administrative proceedings	X	
• law enforcement purposes	X	
• coroners and medical examiners	X	
• for certain research purposes if less than 50 individuals' records were disclosed	X	
• to avert a serious threat to health or safety	X	
• for national security or intelligence purposes		X
• to correctional institutions or law enforcement	X	
• for worker's compensation		X
• for certain marketing, fundraising, or underwriting exceptions	X	

An accounting must include:

- a. date of disclosure;
- b. name of entity or person who received PHI and address, if available;
- c. brief description of PHI disclosed;
- d. brief statement of the purpose of the disclosure that reasonably informs the individual of the basis of the disclosure; or, in lieu of such statement:
  - a copy of the individual's written authorization; or
  - a copy of a written request for a disclosure

Business Associate: \_\_\_\_\_

Disclosure Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Disclosure Recipient**

Name of Entity/Person: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

**Disclosure Information**

Type of Disclosure (check all that apply)

- Claims** - Any information that is part of a claim record.
- Medical Records** – Records that were created by a provider.
- Medical Authorization** - An authorization issued by or on behalf of Blue Cross for purposes of benefits for a service.
- Medical Referral** - A referral from one provider for treatment by another provider.
- Medical Pre-certification** - A determination issued by or on behalf of Blue Cross for purposes of benefits for a service before such service is rendered.
- Enrollment Information** - The application, medical questionnaire, or any other data used for enrollment purposes.
- Premium Bill or Financial Information** - The bill or other financial payment information related to determination or collection of premium or other payment.
- Medical Management Information** - Information related to medical management activities, e.g., eligibility or participation in a preventive program, case management data, prescription drug utilization information.
- Entire Designated Record Set (DRS)** - All information that meets the definition of DRS as defined in the Privacy Rules (164.501)

**What data was included in the disclosed information?**

<input type="checkbox"/> <b>Name</b>	<input type="checkbox"/> <b>Bank or other Financial Account Number</b>
<input type="checkbox"/> <b>Address</b>	<input type="checkbox"/> <b>Credit/Debit card Number</b>
<input type="checkbox"/> <b>Date of Birth</b>	<input type="checkbox"/> <b>Employment Information</b>
<input type="checkbox"/> <b>Phone Number or email address</b>	<input type="checkbox"/> <b>Name/Address of treating provider</b>
<input type="checkbox"/> <b>Member ID</b>	<input type="checkbox"/> <b>Medical History</b> -such as what appears on application
<input type="checkbox"/> <b>Social Security Number</b>	<input type="checkbox"/> <b>Other Information</b> - describe in Purpose for Disclosure field below.
<input type="checkbox"/> <b>Group ID Number</b>	

Reason for Disclosure (check one)

- Required by law
- Certain public health activities
- Health oversight
- For cadaveric organ donation purposes
- Qualified research purposes
- Disclosure not permitted by law

Purpose for Disclosure (required): \_\_\_\_\_



**Member Information**

Member Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Member ID (including alpha pre-fix): \_\_\_\_\_  
SSN # (if different from Member ID): \_\_\_\_\_  
Date of Birth: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Gender: \_\_\_\_\_

**Temporary Suspension of Disclosure**

If applicable, please document direction from a health oversight agency or law enforcement official to suspend accounting of disclosures to the agency or official to avoid impeding enforcement activities. We do not have an affirmative duty to report the disclosure once the suspension has been terminated. The individual would learn about the disclosure if the individual requests another disclosure.

Name of entity requesting a suspension: \_\_\_\_\_  
Suspension period begins \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Suspension period ends \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Signature**

I attest that the above information is correct.

Signature: \_\_\_\_\_ Date: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Print name: \_\_\_\_\_ Phone Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Please sign and mail this form within one month of making the disclosure to:  
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