Texas: Top Utilizers Over $15,000 Request Form
Oklahoma: Top Claims Over $10,000 Request Form

All Corrections MUST be Initialed and Dated by Person from the Account Signing this Request

Must Have Account Number

BCBS Group Number(s): **Enter BCBSTX Group Number(s)**

BCBS Account Number: **Enter BCBSTX Account Number(s)**

BLUE CROSS and BLUE SHIELD OF TEXAS

Re: Request for Reporting of Claims Information Under Texas Insurance Code, Chapter 1215 & Oklahoma Statutes Citationized Title 36. Insurance; Section 4512 – In... 50 or More Employees

Account should check if they want the Broker to receive a copy if the Broker is not the designated recipient (if handwritten – must be initialed & dated by person signing the form)

Texas: Please provide a Top Utilize... xas Insurance Code Sec. 1215.003, which includes a list of claimants for any individual whose t... g the 12-month period preceding the date of the report or the entire coverage period, which ever is s...

Oklahoma: Please provide a Top Clai... ahoma Statutes Citationized Title 36, Section 4512 for claims paid exceeding $10,000 during the 12... e report or the entire coverage period, which ever is shorter.

Provide this information in electronic format to the following person:

Name of Recipient: **{Enter Name of Recipients}**

Email address of Recipient: **{Enter e-mail address of recipient}**

☐ Account requests that a cop... Over $15,000 report go to th...

Check Only One

Statement of Certification for... orts

Plan Sponsor is a mandatory field. See attached FAQ for Examples – Plan Sponsor cannot be an individual.

Group Health Plan's Name is a mandatory field. See attached FAQ for Examples

In order for Blue Cross Blue Shield to provide detailed reports of this nature containing Protected Health Information (PHI), the Group Health Plan must provide a HIPAA Certification. We have chosen the following checked option:

☐ **{Enter PLAN SPONSOR NAME - Cannot be an individual}** ("Plan Sponsor") the sponsor of **{Enter GROUP HEALTH PLAN'S NAME - Cannot be an individual nor solely list BCBS}** ("Group Health Plan") Asks that the certification previously provided to BCBSTX as part of the executed Self-funded Group Health Plan Business Associate Agreement (BAA) or the Insured Group Health Plan Certification documentation be used to provide this report.

☐ **{Enter PLAN SPONSOR NAME - Cannot be an individual}** ("Plan Sponsor") the sponsor of **{Enter GROUP HEALTH PLAN'S NAME - Cannot be an individual nor solely list BCBS}** ("Group Health Plan") hereby certifies that it has complied with the HIPAA Privacy protections and requirements of 45 Code of Federal Regulations § 164.504(f)(2) and that Plan Sponsor will safeguard and limit the use and disclosure of protected health information that the Plan Sponsor may receive from the Group Health Plan to perform the plan administrative functions.

Additional Statements

Plan Sponsor acknowledges that if BCBSTX or BCBSOK releases information, including protected health information, pursuant to this request it is doing so in accordance with Sec. 1215.005 of the Texas Insurance Code or Oklahoma Title 36, Insurance Code Article 45 – Group and Blanket Accident and Health Insurance; Section 4512 and as such is not in violation of a standard of care and is not liable for civil damages resulting from, and is not subject to criminal prosecution for, releasing that information.

Group Health Plan and Plans Sponsor are solely responsible for their compliance to HIPAA Privacy and Security Rules. In the event that GROUP HEALTH PLAN fails to fulfill its obligations under HIPAA, including amending Plan Documents pursuant to HIPAA, unauthorized Use or Disclosure of PHI or any material failure in security measures affecting PHI by any person or entity under the GROUP HEALTH PLAN or Plan Sponsor's control, then Plan Sponsor hereby agrees to indemnify and will hold harmless Blue Cross and Blue Shield of Texas (and any of its officers, directors or employees) from and against any claim, cause of action, liability, damage, cost or expense, including attorneys' fees and court or proceeding costs, arising out of or in... GROUP HEALTH PLAN or Plan Sponsor.

Must be signed by the Account only (not Broker, etc) and the signee should have appropriate signature authority

Signature (Signature of person from the account that has appropriate signature authority)

Printed Name (Plan Sponsor): **{Enter Name of Person Signing from the Account that has appropriate signature authority}**

Title: **{Enter Title}**

Date: **{Enter Date}**

Date the person at the account signed the request form. Date cannot be over 60 days old, if so; a new form needs generated with current date.