



Delta Dental of Oregon Offshore Subcontracting Attestation

Name of Entity Completing Attestation:

<p>Do you or entities that you contract with engage in offshore subcontracting that involves receiving, processing, transferring, handling, storing, or accessing protected health information (PHI)?</p> <p>If "Yes," continue completing the form below and send a copy of this document to delegatecompliance@modahealth.com</p> <p>If "No," the attestation is complete. Please sign and send a copy of this document to delegatecompliance@modahealth.com</p>	<p><input type="checkbox"/> Yes</p> <p><input type="checkbox"/> No</p>
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Part I. Offshore Subcontractor Information

Offshore Subcontractor Name:	
Offshore Subcontractor Country:	
Offshore Subcontractor Address:	
Describe Offshore Subcontractor Functions:	

Effective Date of Offshore Subcontractor (MM/DD/YYYY)	
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Part II. Precautions for PHI

Describe the PHI that will be provided to the offshore subcontractor:	
Discuss why providing PHI is necessary to accomplish the offshore subcontractor objectives:	
Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:	

Part III. Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract

Item	Attestation	Response
1.	Offshore subcontracting arrangement has policies and procedures in place to ensure that Medicare beneficiary PHI and other personal information remains secure.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Offshore subcontracting arrangement prohibits subcontractor's access to Medicare data not associated with the sponsor's contract with the offshore subcontractor.	<input type="checkbox"/> Yes <input type="checkbox"/> No

3.	Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	<input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Offshore subcontracting arrangement includes all required Medicare Part C and D language such as record retention requirements, compliance with all Medicare Part C and D requirements, etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Part IV. Attestation of Audit Requirements to Ensure Protection of PHI

Item	Attestation	Response
1.	Organization will conduct an annual audit of the offshore subcontractor.	<input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Audit results will be used by the organization to evaluate the continuation of its relationship with the offshore subcontractor.	<input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Organization agrees to share offshore subcontractors audit results with Moda Health upon request.	<input type="checkbox"/> Yes <input type="checkbox"/> No

Signature

By signing below, I attest that I have carefully reviewed the information provided on this Attestation Form and attest to its completeness and accuracy, and that I have the authority to sign this Attestation on behalf of the contractor.

Print Name: _____

Print Title: _____

Signature: _____

Date: _____

Please return both documents to Delta Dental of Oregon via the email or mailing address listed below:

Email: delegatecompliance@modahealth.com

Mail: Delta Dental of Oregon/Moda
Attn: Medicare Compliance Department T-17
601 SW Second Avenue
Portland, Oregon 97204-3156