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

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

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

BLUE CROSS & BLUE SHIELD

Re: Request for Reporting of Claims Information Under Texas Insurance Code; Chapter 1215 & Oklahoma Statutes Citationized: Title 36. Insurance; Section 4512 - Insured Employer Health Benefit Plan - 20 or More Employees

Texas: Please provide a Top Utilizers report, information pursuant to Texas Insurance Code Sec. 1215.003, which includes a list of claimants for any individual whose total paid claims exceed $15,000 during the 12-month period preceding the date of the report or the entire coverage period, which ever is shorter.

Oklahoma: Please provide a Top Claims report, information pursuant to Oklahoma Statutes Citationized Title 36, Section 4512 for claims paid exceeding $10,000 during the 12-month period preceding the date of the 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 copy of this report go to the Account's Broker of Record.

Statement of Certification for TX Chapter 1215 Reports & OK Section 4512 (SELECT ONLY ONE)

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 BCBS 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; 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 connection with any such failure on the part of the GROUP HEALTH PLAN or Plan Sponsor.

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

Printed Name (Person signing the form): _____

Title: **{Enter Title}**

Date: **{Enter Date}**