

PROVIDER REQUEST FOR ASSOCIATION WITH AN INDIVIDUAL
ASSESSMENT SUBMISSION AGENT

TO ADD ONE OR MORE IAF SUBMISSION AGENTS

___ I hereby authorize the Department of Developmental Disabilities [DODD] to accept IAF Submissions from the IAF agent named below beginning on the effective date noted. This authorization allows the IAF agent to submit IAF assessments on my behalf; access IAF files and related information such as provider quarterly reports. I understand that:

___ I remain completely and solely responsible for all IAF's submitted on my behalf;

___ It is my responsibility to request access to and view IAF reports, to ensure that IAF's submitted on my behalf are in accordance with what services I actually delivered;

___ The IAF agent named below is acting on my behalf and under my employment, and DODD does not employ, monitor, or guarantee the performance of any IAF agent, nor shall DODD be responsible or liable directly or indirectly for any loss or dispute related to the use of a IAF agent.

___ It is my responsibility for meeting all HIPPA [Health Insurance Portability and Accountability Act] requirements, including having a signed Business Associate Agreement with my IAF agent that explains my IAF agent's obligations for confidentiality. [An example of this agreement can be found on the U.S. Department of Health and Human Services website.]

___ This association with the below IAF agent will remain in effect until I notify DODD in writing that I wish it to be rescinded.

[Initial all 6 lines]

TO ASSOCIATE AN IAF AGENT

___I hereby request the association to the billing agent named below to be rescinded effective on the date noted.

| | |
|-------------------------|--|
| Provider Name: | Provider Medicaid #: |
| Provider Email address: | Provider Phone #: |
| Provider Signature: | Today's Date: |
| IAF Agent Name: | IAF Agent User Code: |
| Effective Beginning: | Effective Ending: [to rescind authorization] |

Fill out and fax to: 614.752.4673, or scan and email to: security-support@list.dodd.ohio.gov

This form supersedes all previous billing agent forms.

--DODD Use Only--

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|---------------------------------------|------------------------|
| Provider Security Affidavit verified: | Association Made: |
| IAF Agent Affidavit verified: | Association Rescinded: |