

**State of Nebraska, Department of Health and Human Services (DHHS)
Medicaid MMIS External Access Confidentiality Statement**

I agree that any and all DHHS information gathered in the performance of my duties, either independently or through access to any DHHS system, shall be held in the strictest confidence.

I understand that DHHS, as a covered entity under HIPAA, must make reasonable efforts to limit my access to protected health information to the minimum necessary to accomplish the intended purpose¹. I agree that information I use, disclose, or request will also be limited to the minimum necessary for the purpose of treatment, payment, or operation.

I agree that any and all information shall be released to no one other than DHHS or authorized individuals in strict compliance with any business agreements or contracts in force.

I agree to meet all applicable state and federal laws and regulations and to comply with all DHHS Security and Privacy Policies, Procedures and Standards.

I acknowledge that in order to maintain compliance with HIPAA standards, the Policies on Information Technology Security are available to me for review and that I have been informed and understand that it is my responsibility to become familiar with and abide by these policies.

I understand that if I wrongfully disclose the information described above, I may be subject to disciplinary action by my employer, and civil and criminal penalties.

I understand that due to security restrictions, DHHS Medicaid (MMIS) information may only be accessed over a secure wired connection. I agree not to access any DHHS Medicaid (MMIS) information over any wireless access device or service.

Employee Information

(Please clearly print all information except for signatures.)

Employee Name: _____

Employee Title/Position _____

Employee Signature _____ **Date** _____

Work Phone _____ **Work E-mail** _____

Employer/Agency Name _____

Address _____ **City** _____ **Zip Code** _____

Employee Work Site (if different than above address) _____

Immediate Supervisor Information

Printed name: _____

Position Title: _____

Work Phone _____ **Work E-mail** _____

Signature: _____

¹ Pursuant to HIPAA 45 CFR 160-164

**State of Nebraska, Department of Health and Human Services (DHHS)
Medicaid MMIS External Access Confidentiality Statement**

Contact Person Information

Contact Person as stated on the Confidentiality Agreement _____

Phone _____ E-mail _____

Employee is requesting external access to claim status for the following Group NPI number(s):

Are you renewing an existing external user ID? _____ If yes, what is the user ID #? _____

Are you replacing existing staff? _____ Yes or no
If Yes, Name _____
Yes or No

Date employee left _____ (OR)

Employee has new position in the same company and still needs existing access _____ Yes _____ No

Position and Location _____