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 purpose[1]. 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**

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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 #?**_____
Yes or no

Are you replacing existing staff? _____ **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 _____