A Message to
Business Office Managers

AmeriHealth

800 Midlantic Drive, Suite 333, Mt. Laurel N.J. 08054

MEMORANDUM

TO: Participating AmeriHealth Ancillary Provider

FROM: Susan Hansen, VP Network Delivery AmeriHealth

Mary Gaffney, HIPAA Project Executive

DATE: June 6, 2001

SUBJECT: HIPAA SURVEY

As you know, the Health Insurance Portability and Accountability Act ("HIPAA") will dramatically affect all healthcare organizations. Part of HIPAA's Administrative Simplification provisions mandate the use of standards for transactions and code sets that insurance companies and other healthcare organizations use when performing electronic exchanges, such as the submission of claims. Health care organizations have until October 16, 2002 to comply with the transaction and code set regulations.

To further implement HIPAA's Administration Simplification provisions, the federal government has published a proposed security regulation and a privacy regulation, which currently has an April 14, 2003 compliance date. These regulations will establish rules and security standards to protect the privacy and confidentiality of individually identifiable health information.

Since the Department of Health and Human Services (HHS) published the final HIPAA transactions and code set rules last year, we have been evaluating and determining how the rules impact our business, the provider community and our group customers. Your completion of the attached survey will assist us in our planning, education and communication efforts.

Please return the completed survey within the next 10 business days to Kim Desmond:

The form can be faxed to Kim at 215-241-4522.If you have any questions about the survey, please contact Kim at 215-241-9072.

We very much appreciate your assistance in gathering this critical information.

AMERIHEALTH HIPAA SURVEY

1. **Name of your organization:**_____

2. **Primary HIPAA contact for your organization:**

   Name:_____
   Title:_____
   Mailing address:_____
   City:_____State_____ ZIP_____
   Phone number: ( )_____
   Fax number: ( )_____
   Email address:_____

3. **What is the level of awareness across your organization of the impact of HIPAA on your operations?** (Please check one.)

   Very Low _____ Low_____ Medium_____ High _____ Very High_____

4. **What is the current level of HIPAA activity within your organization related to:**

   <u>Transactions and Code Sets (Please check one)</u>

   None _____
   Developing plan to conduct gap assessment _____
   Gap assessment begun _____
   Gap assessment completed and plan under development _____
   Plan completed and execution underway _____
   Other (Please explain below.) _____

   _____
   _____
   _____
   _____

   If your organization has a contact (other than the Primary contact listed above) for the Transactions and Code Sets, please provide the following information:

   Name:_____
   Title:_____
   Mailing address:_____
   City:_____State_____ ZIP_____
   Phone number: ( )_____
   Fax number: ( )_____
   Email address:_____

AMERIHEALTH HIPAA SURVEY
Page Two

Security (Please check one.)

None _____
Developing plan to conduct gap assessment _____
Gap assessment begun _____
Gap assessment completed and plan under development _____
Plan completed and execution underway _____
Other (Please explain below.) _____

_____
_____
_____
_____

If your organization has a contact specifically for Security, please provide the following information:

Name: _____
Title: _____
Mailing address: _____
City: _____State_____ ZIP_____
Phone number: ( )_____
Fax number: ( )_____
Email address: _____

Privacy (Please check one.)

None _____
Developing plan to conduct gap assessment _____
Gap assessment begun _____
Gap assessment completed and plan under development _____
Plan completed and execution underway _____
Other (Please explain below.) _____

_____
_____
_____
_____

If your organization has a contact specifically for Privacy, please provide the following information:

Name:_____
Title:_____
Mailing address:_____
City:_____State_____ ZIP_____
Phone number: ( )_____
Fax number: ( )_____
Email address:_____

AMERIHEALTH HIPAA SURVEY
Page Three

5. Does your organization currently participate in electronic transactions with AMERIHEALTH?

Yes____ No_____

6. If yes, which ones?

Claims _____ Eligibility Status _____ Remittances _____
Other (Please specify.)_____
_____

7. If your organization currently submits electronic transactions to AMERIHEALTH, are they submitted to us directly from your facility or through a clearinghouse or vendor(s)?

Directly ____ Clearinghouse/Vendor(s) ____

If you checked clearinghouse/vendor(s), please provide the following information:

First Vendor's Name:_____
Address:_____
_____
Phone Number: ( )_____
Contact Name:_____

Second Vendor's Name:_____
Address:_____
_____
Phone Number: ( )_____
Contact Name:_____

8. If your organization currently supports electronic transmissions with other payers, please identify the HIPAA transaction(s) below. (Please check all applicable transactions.)

837	Health Care Claim or Encounter	_____
835	Health Care Claim Payment/Remittance	_____
270	Health Insurance Eligibility Request Verification for Covered Benefits	_____
271	Health Insurance Eligibility Response Verification for Covered Benefits	_____
834	Enrollment/Disenrollment to a Health Plan	_____
276	Health Care Claim Inquiry to Request the Status of a Claim	_____
277	Health Care Claim Response to Report the Status of a Claim	_____
278	Health Care Services, to Request Authorizations and Referrals	_____
820	Premium Payment for Enrolled Health Plan Members	_____

9. **What are your organization's expectations of AMERIHEALTH in regard to implementation of HIPAA?**_____
_____
_____
_____

AMERIHEALTH HIPAA SURVEY
Page Four

10. Would you be interested in participating in an AMERIHEALTH-sponsored HIPAA education session?

Yes____ No_____

11. Is your organization aligned with any HIPAA implementation group(s)?

Yes____ No_____

If so, which one(s)? _____
_____

12. Name of person completing this survey:

Name:_____
Title:_____
Address:_____
City:_____ State_____ ZIP_____
Phone number: ( )_____
Fax number: ( )_____
Email address:_____

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