

Business Associate Confirmation Form



*Account Name & Number:	
*Contact Name:	*Phone Number:
*Address:	
*Sales Rep Name and Phone Number:	
The Group Health Plan identified in the Account Name & Number section above has contracted with the Business Associates identified below to further administration of the Group Health Plan. Please complete a new form when changes to your relationship with your Business Associates change.	
* Name of Business Associate:	*Effective/Termination Date:
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* Name of Business Associate:	*Effective/Termination Date:

* Required Information. We cannot share any PHI with your business associates until we have this information on file. Forms received without this information will be returned.

Sales Representatives should forward this complete, signed form to:

CareFirst BlueCross BlueShield
Privacy Office
10455 Mill Run Circle
Owings Mills, MD 21117
Fax: 410-505-6692
Email: privacy.office@carefirst.com

Signature

Title

Date