NationsHearing

Offshore Services / Subcontractor Attestation

Offshore Subcontractor Required Information
Offshore Subcontractor Name: _____
Offshore Subcontractor Country: _____
Offshore Subcontractor Address: _____
Describe Offshore Subcontractor Functions: _____ _____
State Proposed or Actual Effective Date for Offshore Subcontractor: _____ /_____ /_____
Describe the PHI that will be provided to the Offshore Subcontractor: _____ _____ _____
Discuss why providing PHI is necessary to accomplish the Offshore Subcontractor objectives: _____ _____
Describe alternatives considered to avoid providing PHI, and why each alternative was rejected: _____ _____ _____

Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract		
Item	**Attestation**	**Response**
1.	Offshore subcontracting arrangement has policies and procedures in place to ensure that Medicare beneficiary PHI and other personal information remains secure.	☐ Yes ☐ No
2.	Offshore subcontracting arrangement prohibits subcontractor's access to Medicare data not associated with the plan sponsor's contract with the offshore subcontractor.	☐ Yes ☐ No
3.	Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	☐ Yes ☐ No
4.	Offshore subcontracting arrangement includes all required Medicare (CMS) language.	☐ Yes ☐ No

Attestation of Audit Requirements to ensure protection of PHI		
Item	**Attestation**	**Response**
1.	Organization will conduct an annual audit of the offshore subcontractor.	☐ Yes ☐ No
2.	Audit results will be used by the Organization to evaluate the continuation of its relationship with the offshore subcontractor.	☐ Yes ☐ No
3.	Organization agrees to share offshore subcontractor's audit results with CMS and/or plan sponsor, upon request.	☐ Yes ☐ No

I certify, as an authorized representative of my organization, that the statements made above are true and correct to the best of my knowledge. Also, my organization agrees to maintain documentation supporting the statements above. My organization will produce evidence of the above to NationsHearing or CMS upon request.

_____ _____

Signature of Provider Organization's Authorized Representative Date