INSTRUCTIONS

Below are instructions on how to fill out the **Statement of Acceptable Use** form to obtain a Claims Data Report from the State Health Benefit Plan ("SHBP") for the purpose of either: (1) obtaining premium bids for health insurance coverage from health plans other than the SHBP (as permitted by law), or (2) for the purpose of determining whether to **terminate SHBP coverage for all or some of the non-certified Board of Education employees only.** SHBP cannot provide any claims data information regarding retirees unless he retiree was an active employees during the time frame perimeters for the claims data.

1. Print and read the entire form.
2. Complete all applicable portions.
3. The person authorized to sign on behalf of the employing entity MUST sign the completed form and provide his/her contact information. Failure to provide an authorized signature will result in SHBP failing to provide the requested information.
4. Mail the originally executed **Statement of Acceptable Use** form to the attention of the person(s) listed on the form. Include applicable payment for the claims data report (standard or custom report; with or without CD/DVD, per report).

Claims Data Reports requested for multiple payroll locations will not be accepted unless a Statement of Acceptable Use form is prepared and submitted for *each individual location.* Rates/Fees will apply for each individual request submitted. SHBP will accept one (1) request for a Claims Data Report per payroll location every six (6) months. Requests will not be honored if made prior to the six month waiting period or if an entity has an outstanding invoice for a previous request. **No requests regarding certified employees will be accepted.**

FEES

$150.00 – **Standard Report Package**. Fee is due with the submission of the **Statement of Acceptable Use** form.

$150.00 – **Custom Report Package**, plus an hourly rate of $28.00 for research and custom, detailed analyst report. You must request either: (i) a two year Plan report; (ii) a 24 consecutive month report, or (iii) a report for a time period longer than two years or 24 consecutive months. Authorized person(s) will receive an invoice prior to the release of the Claims Data Report for the hourly rate incurred to customize the report. The invoice must be paid in full prior to SHBP release. **All payments should be made out to: "Department of Community Health – Decision Support Services, 2 Peachtree Street, N.W., Atlanta, Georgia 30303."** Fee rates are subject to change without prior notice from the Plan Administrator or SHBP. New rates will be posted on the **Statement of Acceptable Use** form.

THE RELEASE OF PERSONAL HEALTH INFORMATION ("PHI") IS A VIOLATION OF DCH REGULATION, GEORGIA STATE LAW AND HIPAA PRIVACY LAWS AND ARE SUBJECT TO FINES, PENALTIES OR BOTH. VIOLATORS WILL BE PROSECUTED TO THE FULLEST EXTENT OF THE LAW.

STATE HEALTH BENEFIT PLAN
STATEMENT OF ACCEPTABLE USE / REQUEST FOR CLAIMS DATA REPORT

This report designed to provide information that is "de-identified" within the meaning of the HIPAA Privacy regulations. However, if you are able to identify any individual from the report as a result of information you have, this report is considered "summary health information" as defined in 45 C.F.R § 164.504[1], and is provided to you in your capacity as a “plan sponsor” of the State Health benefit Plan (“SHBP”) (for purpose of this report only) with respect to the individuals coverage as a result of current or past employment with your organization.

By accepting this report, you affirm that you requested this report for one of the following reasons:

- For the purpose of obtaining premium bids for health insurance coverage from health plans other than the SHBP, which bids would be for the purpose of providing health insurance coverage under a group health plan (to the extent permitted by law, or
- For the purpose of determining whether to terminate SHBP coverage for all or some of your employees and retirees (to the extent permitted by law).

Note: Certified Personnel of the local boards of education are legislatively required to participate in the SHBP. Therefore, DCH is unable to provide data for Certified Personnel for the purposes outlined above and this form cannot be used for that purpose.

SECTION 1: AFFIRMATION FOR USE OF CLAIMS DATA REPORT

By submitting this **Statement of Acceptable Use** form, you affirm that you are requesting this report for use and purpose of one of the following reasons:

☐ For the purpose of obtaining premium bids for health insurance coverage from health plans other than the SHBP, which bids would be for the purpose of providing health insurance coverage under a group health plan for your entity (to the extent permitted by law), or

☐ For the purpose of determining whether to terminate SHBP coverage for all or some of the employees and retirees presently participating through at the Employing Entity (to the extent permitted bylaw).

SECTION 2: TYPE OF CLAIMS DATA REPORT

☐ Standard Report Package Fee: $150.00 due immediately

- ☐ Standard Report Option 1 – Last Two Complete Plan Years
- ☐ Standard Report Option 2– Last Consecutive Twenty-Four Month period

☐ Custom Report Package – Fee: $150.00 plus hourly rate of $28.00 ($150.00 due immediately; hourly rate to be determined at the conclusion of report preparation. Amount will be based on time spend for research, preparation and detailed analysis of report).

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45 C.F.R. § 164.504(a) defines Summary health information as information, that may be individually identifiable health information, and: (1) That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and (2) From which the information described at §164.514(b)(2)(i) has been deleted, except that the geographic information described in §164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code.

SECTION 3: AUTHORIZATION

Name of Payroll Location/Employing Entity

By signing and submitting this **Statement of Acceptable Use** form, you agree to take any and all necessary steps to ensure that the information provided to you in the claims data report will be used for the purpose attested to in Section 1 above, only. Additionally, if you are not the Employer, by signing you certify the Employer has authorized you to receive the claims data report on the Employer's behalf.

AGREED TO BY:

Authorized Signature	Title
Print Name Here	Company Name
Address	Telephone Number
City, State Zip Code	Email
Date	

All applicable fees and the completed **Statement of Acceptable Use** form should be remitted to:

Gynorris A. Davis
Georgia Department of Community Health
State Health Benefit Plan, Floor 19
2 Martin Luther King Jr. Drive S.E., East Tower
Atlanta, GA 30334