

## Approval to Communicate with Third Parties on Behalf of a Medicare Provider

In the process of performing audit work, the Medicare Audit staff at WPS may need to communicate with a Medicare provider to request additional information or clarification. We may also need to send information such as adjustments, rates, etc. to the Medicare provider. The Medicare agreement that the provider operates under is between CMS and the Medicare provider. Medicare FI/MACs also have an operating agreement with CMS. Both of these agreements require that we follow HIPAA and other various Privacy laws that require us to protect confidential information. As such, we must generally limit our communication about provider or beneficiary specific information to the Medicare provider only.

We are aware that many providers choose to outsource some of their Medicare cost reporting functions to consulting firms or other external parties. Before we are able to discuss any provider-specific information, we must have signed approval from the Medicare provider explicitly authorizing us to work with the third party. Please note that any Protected Health Information (PHI) and/or Personally Identifiable Information (PII) requests must still be routed through the Medicare provider themselves.

This approval may be in the form of a letter from the provider on their own letterhead, or the provider may choose to fill out the form below. Please note that any approval will be effective for the fiscal year or specific project in question.

Provider Number (CMS Certification Number): \_\_\_\_\_

Provider Name: \_\_\_\_\_

FYE this authorization is effective for: \_\_\_\_\_

**Please fill out the below information regarding this third party that you are requesting we work with on your behalf.**

Contact Name: \_\_\_\_\_

Contact Address: \_\_\_\_\_

Contact Phone Number: \_\_\_\_\_

Contact Email Address: \_\_\_\_\_

Contact Type: \_\_\_\_\_

Type of reviews to contact this third party for: \_\_\_\_\_

I hereby authorize WPS and its employees to contact the above listed individuals(s) and share any information, adjustments, requests, etc. related to the review or audit described above, subject to any limitations also described above. This authorization will be in effect only for the specific fiscal year or project detailed above. This authorization may be terminated earlier by notifying WPS of a rescission of this authorization or a new contact that should be used.

\_\_\_\_\_  
Signature and Title of Authorized Administrator of Medicare Provider

\_\_\_\_\_  
Date