



Medicare Advantage Offshore Services Consent Request and Attestation

You are a participating provider who has agreed to offer services to covered members of Medicare Advantage plans offered by Wellmark, Inc., or its affiliates including Wellmark Advantage Health Plan, Inc. (collectively "Wellmark"). In connection with Wellmark's Part C and Part D obligations and as required by your agreement with Wellmark, you must obtain Wellmark's prior written consent before any function, activity or service related to your agreement with Wellmark, including, without limitation, storage of or access to Medicare Advantage member information, is performed by any person or entity outside of the United States of America or its territories. This form is to facilitate the prior written consent process.

If you intend to use offshore services for a function Wellmark has contracted with participating provider to perform, including those that involve receiving, processing, transferring, handling, storing, or accessing Wellmark Medicare Advantage member protected health information ("PHI"), you are required to complete the below information prior to the commencement of the services for each offshore subcontractor. Participating provider must notify Wellmark at least 60 days in advance of the participating provider's intent to use a new offshore entity or before employing new offshore staff. You must also submit this form for existing vendors that will commence services for Wellmark Medicare Advantage members. **Wellmark will review this submission and respond to the request. Submission of this form alone does not constitute prior written consent.**

Offshore Services Information

Offshore entity legal name: _____

Offshore entity d/b/a: _____

Offshore entity country or countries, if multiple locations:

Offshore entity address or addresses, if multiple locations:

(The offshore entity address should include the full address for each offshore location, including the country, which will receive, process, transfer, handle, store or access PHI).

Describe offshore functions the offshore entity will perform ("offshore services"):

State the proposed or actual effective date of the offshore services:

(The proposed or actual effective date is either the effective date of the Medicare contract with Wellmark or the effective date of contract with the entity, whichever is later. The proposed or actual effective date for the services must include the month, date and year. Please use this format: MM/DD/YYYY). ____/____/____



Describe the member PHI that will be provided to the offshore entity:
(Please check the boxes to identify the types of PHI the offshore entity may access.)

- ☐ Name
- ☐ Age
- ☐ Date of birth
- ☐ Address
- ☐ Phone number
- ☐ Full SSN
- ☐ Partial SSN (last four)
- ☐ Medicare/HICN
- ☐ Wellmark member ID
- ☐ Prescription history
- ☐ Claim history
- ☐ Diagnosis
- ☐ Medical history
- ☐ Banking/financial information
- ☐ Other (provide detailed description below)

Explain why providing PHI is necessary to accomplish the offshore services:

Describe any and all alternatives considered to avoid providing PHI offshore. Why was each alternative rejected?
(When describing any alternatives considered to avoid using PHI, be sure to include the reason why the alternative was rejected.)



Name of participating provider: _____

Offshore entity name: _____

With respect to the offshore services provided by the above-named offshore entity, participating provider certifies and attests that:

- 1. The agreement participating provider has with the offshore entity requires the offshore entity to have policies and procedures in place to ensure Wellmark’s Medicare Advantage Plans’ PHI remains secure.
☐ Yes ☐ No
- 2. The agreement participating provider has with the offshore entity prohibits the offshore entity’s access to data not associated with the agreement.
☐ Yes ☐ No
- 3. The agreement with the offshore entity allows participating provider to immediately terminate the offshore services upon discovery of a significant security breach.
☐ Yes ☐ No
- 4. The agreement between participating provider and the offshore entity includes all required Medicare Part C and D language (e.g., record retention requirements, compliance with Medicare Part C and D requirements, etc.).
☐ Yes ☐ No
- 5. Participating provider conducts an annual audit or review of its relationship with the offshore entity and monitors offshore staff’s access to PHI. Participating provider agrees to share a summary of audit and monitoring activities and findings with Wellmark, or directly with CMS, upon request. NOTE: CMS recommends that the audit be performed onsite.
☐ Yes ☐ No
- 6. The results from the annual audit or review are used to evaluate the continuation of the relationship with the offshore entity.
☐ Yes ☐ No

Please provide a brief explanation for any “no” responses for the statements above.



Attestation Authorization

I certify, as an individual authorized to bind participating provider, that the statements made above are true and correct to the best of my knowledge. In addition, participating provider organization agrees to maintain documentation supporting the statements listed above. My organization will produce evidence of the above to Wellmark or CMS upon request. My organization understands that the inability to produce this evidence may result in a Corrective Action Plan or other Wellmark contractual remedies, such as a contract termination.

Participating provider's authorized representative printed name and title

Signature of participating provider's authorized representative

Date

Participating provider name (printed)

Tax ID#

Participating provider's authorized representative mail address

Participating provider's authorized representative phone number and email address

Please return completed form to the following: FDROversight@wellmark.com