CHECKLIST TO COMPLETE
A HIPAA PRIVACY AND SECURITY ASSESSMENT

[Note: If an employer completes this Checklist, Palmieri & Eisenberg is able to prepare a comprehensive package of documents to help an employer comply with the HIPAA Privacy Rules that became effective as of April 14, 2003 for large health plans with premiums and/or annual receipts exceeding $5 million (April 14, 2004 for smaller employers); and April 20, 2005 for the Security Rules for large employers (April 20, 2006 for small health plans).]

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Date: _____

1. **Plan Name**: _____.
   Plan Number: _____.
   Approximate Number of Plan Participants: _____.
   Approximate Annual Receipts or Premium: _____.

2. **Plan Sponsor**: _____.
   State of Incorporation: _____.
   EIN Number: _____.
   Address: _____.
   _____.
   Telephone Number: (___) _____ - _____.
   Fax Number: (___) _____ - _____.
   email/website: _____.
   Number of Employees: _____.

3. **Related Entities**:

   a. Name: _____.
      Address: _____.
      State of Incorporation: _____.
      EIN Number: _____.
      Number of Employees: _____.

   b. Name: _____.
      Address: _____.
      State of Incorporation: _____.
      EIN Number: _____.
      Number of Employees: _____.

c. Name: _____.
Address: _____.
State of Incorporation: _____.
EIN Number: _____.
Number of Employees: _____.

d. Name: _____.
Address: _____.
State of Incorporation: _____.
EIN Number: _____.
Number of Employees: _____.

4. **Health Plan Administrative Status**.

a. **Active Administration**: [ ] Yes; [ ] No.
(Active administration includes responding to employee questions regarding coverages, helping employees with Explanation of Benefit ("EOB") Forms to obtain reimbursements, filing claims, helping with appeals, and identifying covered services.)

b. **Not Involved in Plan Administration**. [ ] Yes; [ ] No.

c. **Not Involved in Plan Administration, but will help Employees upon Receipt of an Authorization Form**. [ ] Yes; [ ] No.

5. **Plan Information**. Please provide a copy of the most recent Form 5500's filed for all welfare plans (if possible) to confirm all Plan Numbers, Plan Years and past actions.

a. **Health Plans**:

i. **Self-Insured Plan**.
Plan Name: _____.
TPA Contact Person: _____.
Telephone Number/Fax: _____.
Email: _____.
Address: _____.

ii. **HMO**:
Plan Name: _____.
Carrier Contact Person: _____.
Telephone Number/Fax: _____.
Email: _____.
Address: _____.

iii. **PPO**:
Plan Name: _____.
Carrier Contact Person: _____.
Telephone Number/Fax: _____.
Email: _____.
Address: _____.

iv. **POS**:
Plan Name: _____.
Carrier Contact Person: _____.
Telephone Number/Fax: _____.
Email: _____.
Address: _____.

v. **Other**:
Plan Name: _____.
Carrier Contact Person: _____.
Telephone Number/Fax: _____.
Email: _____.
Address: _____.

b. **Prescription Drug**:

Plan Name: _____.
Insurance Contact Person: _____.
Telephone Number/Fax: _____.
Email: _____.
Address: _____.

c. **Vision**:

Plan Name: _____.
Insurance Contact Person: _____.
Telephone Number/Fax: _____.
Email: _____.
Address: _____.

d. **Dental**:

Plan Name: _____.
Insurance Contact Person: _____.
Telephone Number/Fax: _____.
Email: _____.
Address: _____.

e. **Medical Flexible Spending Account ("FSA")**:

Plan Name: _____.
Medical FSA Limit: _____.
TPA Name: _____.
TPA Contact Person: _____.
Telephone Number/Fax: _____.
Email: _____.
Address: _____.

f. **Employee Assistance Programs**:

Plan Name: _____.
Insurance Contact Person: _____.
Telephone Number/Fax: _____.
Email: _____.
Address: _____.

g. **Retiree Medical**:

Plan Name: _____.
Insurance Contact Person: _____.
Telephone Number/Fax: _____.
Email: _____.
Address: _____.

h. **Executive Health Benefits**:

Plan Name: _____.
Insurance Contact Person: _____.
Telephone Number/Fax: _____.
Email: _____.
Address: _____.

i. **Long-Term Care**:

Plan Name: _____.
Insurance Contact Person: _____.
Telephone Number/Fax: _____.
Email: _____.
Address: _____.

5. **Other Covered Entities**

a. **Onsite Clinic**: _____
_____.

b. **Healthcare Providers**: _____
_____.

6. **Provider Information**

a. **Payroll Provider**:

Company Name: _____.
Contact Person: _____.
Telephone Number/Fax: _____.
Email: _____.
Address: _____.

b. **COBRA Provider/Internal Administrator**:

Name: _____.
Contact Person: _____.
Telephone Number/Fax: _____.
Email: _____.
Address: _____.

c. **Stop Loss Carrier**:

Name: _____.
Contact Person: _____.
Telephone Number/Fax: _____.
Email: _____.
Address: _____.

d. **Insurance Broker**:

Name: _____.
Contact Person: _____.
Telephone Number/Fax: _____.
Email: _____.
Address: _____.

e. **Benefits Consultant**:

Name: _____.
Contact Person: _____.
Telephone Number/Fax: _____.

Email: _____.
Address: _____.

f. **Disease Management Firms**:

Name: _____.
Contact Person: _____.
Telephone Number/Fax: _____.
Email: _____.
Address: _____.

g. **Utilization Review and Large Case Management**:

Name: _____.
Contact Person: _____.
Telephone Number/Fax: _____.
Email: _____.
Address: _____.

h. **Subrogation Firm**:

Name: _____.
Contact Person: _____.
Telephone Number/Fax: _____.
Email: _____.
Address: _____.

i. **Claims Auditor**:

Name: _____.
Contact Person: _____.
Telephone Number/Fax: _____.
Email: _____.
Address: _____.

j. **Medical Network Provider**:

Name: _____.
Contact Person: _____.
Telephone Number/Fax: _____.
Email: _____.

Address: _____.

k. **The Auditors for the Plan**:

Name: _____.
Contact Person: _____.
Telephone Number/Fax: _____.
Email: _____.
Address: _____.

l. **Shredding Company**:

Name: _____.
Contact Person: _____.
Telephone Number/Fax: _____.
Email: _____.
Address: _____.

m. **ERISA Attorney**:

Name: Palmieri & Eisenberg
Contact Person: Frank Palmieri
Telephone Number/Fax: (609) 497-0400; (609) 497-1163
Email: fpalmieri@p-ebenefitslaw.com
Address: 715 Executive Drive, Princeton, NJ 08540

7. **Miscellaneous**.

a. **HR System**:
Name: _____.
Supporting Entity: _____.
Contact Person: _____.
Telephone Number/Fax: _____.
Email: _____.
Address: _____.

b. **STD:**
Plan Name: _____.
Benefit: _____% of pay up to _____ per week/month for _____ week/months.
Insurance Contact Person: _____.
Telephone Number/Fax:_____.
Email: _____.
Address: _____.

c. **LTD:**

Plan Name: _____.
Benefit: _____% of pay up to _____ per week/month for _____ week/months.
Insurance Contact Person: _____.
Telephone Number/Fax:_____.
Email: _____.
Address: _____.

d. **AD&D:**

Plan Name: _____.
Benefit: $_____.
Insurance Contact Person: _____.
Telephone Number/Fax:_____.
Email: _____.
Address: _____.

e. **Life Insurance:**

Plan Name: _____.
Benefit: _____ x salary up to $_____ for a maximum benefit of $_____.
Insurance Contact Person: _____.
Telephone Number/Fax:_____.
Email: _____.
Address: _____.

f. **Workmen's Compensation:**

Plan Name: _____.
Insurance Contact Person: _____.
Telephone Number/Fax:_____.
Email: _____.
Address: _____.

g. **Drug Testing:**

[ ] Pre-employment.
[ ] Post-Accident.
[ ] Random.
[ ] Reasonable Cause.
[ ] N/A - Do Not Perform any Drug Testing.

Name of Drug Testing Service: _____.
Contact Person: _____.
Telephone Number/Fax:_____.
Email: _____.
Address: _____.

8. **Human Resource Contacts**.

Please list all members of the Human Resources and related Department including those not involved with the Health Plans such as recruiters, as well as members of the IT Department. An **HR Organizational Chart may be provided**, if marked up to identify the location of all employees.

a. **VP HR**:
Name: _____.
Telephone Number/Fax: _____.
Email: _____.
Location/Address: _____.

b. **Director of HR**:
Name: _____.
Telephone Number/Fax: _____.
Email: _____.
Location/Address: _____.

c. **HR Manager**:
Name: _____.
Telephone Number/Fax: _____.
Email: _____.
Location/Address: _____.

d. **Benefits Manager or Specialist**:
Name: _____.
Telephone Number/Fax: _____.
Email: _____.
Location/Address: _____.

e. **HR Generalist**:
Name: _____.
Telephone Number/Fax: _____.
Email: _____.
Location/Address: _____.

f. **HR Supervisor**:

Name: _____.
Telephone Number/Fax: _____.
Email: _____.
Location/Address: _____.

g. **Recruiter**:
Name: _____.
Telephone Number/Fax: _____.
Email: _____.
Location/Address: _____.

h. **Other**:
Name: _____.
Telephone Number/Fax: _____.
Email: _____.
Location/Address: _____.

i. **Other**:
Name: _____.
Telephone Number/Fax: _____.
Email: _____.
Location/Address: _____.

j. **IT Manager**:
Name: _____.
Telephone Number/Fax: _____.
Email: _____.
Location/Address: _____.

k. **Potential Privacy Officials:**

i. Name: _____.
Telephone Number/Fax: _____.
Email: _____.
Location/Address: _____.

ii. Name: _____.
Telephone Number/Fax: _____.
Email: _____.
Location/Address: _____.

l. **Complaint Manager:**
Name: _____.
Telephone Number/Fax: _____.

Email: _____.
Location/Address: _____.

m. **Employee Contacts:**
Name: _____.
Telephone Number/Fax: _____.
Email: _____.
Location/Address: _____.

n. **Employee Contacts:**
Name: _____.
Telephone Number/Fax: _____.
Email: _____.
Location/Address: _____.

o. **Miscellaneous Comments/Questions:**

a. _____
_____.

b. _____
_____.

c. _____
_____.

Under Circular 230, any advice in this Summary concerning a federal tax issue is not intended or written to be used, and cannot be used by any taxpayer, for the purpose of avoiding any tax penalties that can be imposed by the Internal Revenue Service, or for promoting, or marketing any tax matters.

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