Interoperability Form for Payers

Interoperability for payers refers to the ability of health insurance companies (health plans or “payers”) to securely, electronically exchange health information with other payers, using standardized formats and technology. The goal is to ensure that health information can move with the member and be accessed when needed, even when moving from one payer to another.

Health insurance companies exchange this information using secure technologies called Application Programming Interfaces (APIs). An API allows different computer systems to connect and share data reliably and efficiently.

Your health plan can use the Payer Access Interface to safely share your health information with another insurance company. This gives quick access to important information, like past care, and health information.

By choosing to Opt In to sharing this data with your health insurance payer, you can support continuity of care so that your health plan has the information it needs to better understand your health history and help you get the care you need.

You may choose whether or not to allow payer-to-payer information sharing. Your choice will not affect your eligibility for coverage or benefits.

Interoperability Form

- **INTEROPERABILITY MEMBER CONSENT FOR PAYER API -** We will not request this information from another payer unless you provide written consent using the Interoperability Member Consent Payer API form.

For additional information on Interoperability please visit our website at https://www.cdphp.com/

Please keep a copy for your records

INTEROPERABILITY MEMBER CONSENT FOR PAYER API

The purpose of this authorization is to allow Capital District Physicians' Health Plan, Inc. (“Health Plan”) to access your health information from your previous and/or current health insurance carrier through the Payer Access API. This authorization allows you to opt in to the sharing of general health information and sensitive diagnosis information.

Authorization to the Health Plan to Access Protected Health Information (PHI) Through the Payer Access API

Section I: Member Information

Last Name	First Name	Middle Initial	Date of Birth

Street Address	City	State	Zip Code

Member Identification Number (located on member ID card)

Section II: Sharing Information

Please list the name(s) of any previous and/or current health plan(s) for which you authorize the exchange of your health information. Include the member identification number associated with each policy from which you would like data to be retrieved and shared.

Payer Name:	Member Identification Number:	Is this a current policy? (select one)
Payer Address:		☐ Yes, this is a current policy ☐ No, this is a previous policy

Payer Name:	Member Identification Number:	Is this a current policy? (select one)
Payer Address:		☐ Yes, this is a current policy ☐ No, this is a previous policy

Section III: Reason for Member/Individual Authorizing Disclosure

☐ Interoperability

Section IV: General Data Sharing

Complete this section if you choose to opt in to general information sharing.

_____ By initialing here, I agree to allow the Health Plan to retrieve my protected health information (PHI) from the payer(s) indicated in Section II.

Continued on next page

Section V: Sensitive Data Sharing

Complete this section if you are choosing to share sensitive data with the Health Plan. By opting in, you authorize the Health Plan to share sensitive diagnosis information. **Note:** If signing on behalf of a minor, this authorization applies only to mental health, and genetic testing information. Sharing of other listed sensitive diagnosis requires the minor's signature.

Information to Be Disclosed

_____ By initialing here, I agree to allow the Health Plan to retrieve my protected health information (PHI) for all of the below conditions with the payer(s) indicated in Section II:

- Genetic testing information
- Sexually transmitted diseases (STDs)
- Substance use disorder treatment
- Abortion-related information
- Mental health information
- HIV/AIDS information

Section VI: Acknowledgement (Please read and sign)

I understand that:

- I can revoke this authorization at any time by writing to the Health Plan at the address listed below except this revocation would not affect any action taken by the Health Plan in reliance on this authorization before my written revocation is received.
- Information disclosed as a result of this authorization may be re-disclosed by the recipient. Federal and state privacy laws may no longer protect my PHI.
- Health Plan will not condition my enrollment in a health plan, eligibility for benefits or payment of claims on my giving this authorization.
- This authorization will remain in effect until the Health Plan receives my written cancelation notice, or, until the date I specify here: _____

IMPORTANT: I have read and understand the terms of this authorization. I hereby authorize the use and disclosure of my protected health information in the manner described in this form.

Signature: _____ Date: _____

If this request is from a personal representative on behalf of the member, complete the following:

Personal Representative's Name: _____

Personal Representative's Signature _____ Date: _____
Description of Authority: ☐ Parent ☐ Legal Guardian* ☐ Power of Attorney*
☐ Other* _____
**You must provide documentation supporting your legal authority to act on behalf of the member*

Return To:
Capital District Physicians' Health Plan, Inc.
P.O. Box 21494
Eagan, MN 55121