Vendor Approver Certification

DHCS Approved (DHCS use only)
Date **Approver**

For Access to Confidential DHCS Drug Medi-Cal Information

Vendor: ______________________________

To ensure the confidentiality of county/direct provider Drug Medi-Cal data, the Department of Health Care Services (DHCS) requests the designated vendor identify a primary and a secondary contact to be responsible for approving requests for access to confidential county/direct provider Drug Medi-Cal patient data. Please provide this information in the spaces below and fax this form to (916) 323-0653. If you have questions about this form, please call (916) 323-2043.

Primary Vendor Approver:

First Name: ____________________ Last Name: ____________________

Title: ______________________________

Phone Number: ____________________ Fax Number: ____________________

Email Address: ______________________________

Primary Approver's Signature: ______________________________
(Signer acknowledges having read the Confidentiality Statement for all DHCS AOD users of the ITWS)

Secondary Vendor Approver:

First Name: ____________________ Last Name: ____________________

Title: ______________________________

Phone Number: ____________________ Fax Number: ____________________

Email Address: ______________________________

Secondary Approver's Signature: ______________________________
(Signer acknowledges having read the Confidentiality Statement for all DHCS AOD users of the ITWS)

Vendor for the Following Counties/Direct Providers:

(Please indicate two digit County number, four digit DMC Direct Provider number)

________	________	________	________	________
________	________	________	________	________
________	________	________	________	________
________	________	________	________	________

Vendor Certification:

As ____________ (title) for ____________________ (vendor), I certify this organization is a vendor for the above counties/direct providers and designate the individuals identified above to have independent authority to approve access requests to specific confidential county/direct provider Drug Medi-Cal patient data. DHCS may rely on approvals, denials, and changes made by these individuals in its processing of access requests for the above listed counties'/direct providers' data. As changes occur to the above approving contacts (name, phone, e-mail or county/direct provider), I will complete a new certification and forward it to DHCS. Also, I acknowledge reading the Confidentiality Statement for all DHCS AOD users of the ITWS.

Name/Signature: ______________________________ (printed/signed) Date: ____________

Title: ______________________________