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 _____ for _____, I certify this organization is a vendor for
(title) (vendor)
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: _____