MODA Health
Offshore Subcontracting Attestation

Name and Address of Entity/Provider Completing Attestation:

Do you or entities that you contract with engage in offshore subcontracting that involves receiving, processing, transferring, handling, storing, or accessing protected health information (PHI)? If "Yes," continue completing the form below and send a copy of this document to delegatecompliance@modahealth.com If "No," the attestation is complete. Please sign and send a copy of this document to delegatecompliance@modahealth.com	☐Yes ☐No

Part I. Offshore Subcontractor Information

Offshore Subcontractor Name:	
Offshore Subcontractor Country:	
Offshore Subcontractor Address:	
Describe Offshore Subcontractor Functions:	

Effective Date of Offshore Subcontractor (MM/DD/YYYY)	

Part II. Precautions for PHI

Describe the PHI that will be provided to the offshore subcontractor:	
Discuss why providing PHI is necessary to accomplish the offshore subcontractor objectives:	
Describe alternatives considered to avoid providing PHI, and why each alternative was rejected:	

Part III. Attestation of Safeguards to Protect Beneficiary Information in the Offshore Subcontract

Item	Attestation	Response
1.	Offshore subcontracting arrangement has policies and procedures in place to ensure that Medicare beneficiary PHI and other personal information remains secure.	☐Yes ☐No
2.	Offshore subcontracting arrangement prohibits subcontractor's access to Medicare data not associated with the sponsor's contract with the offshore subcontractor.	☐Yes ☐No
3.	Offshore subcontracting arrangement has policies and procedures in place that allow for immediate termination of the subcontract upon discovery of a significant security breach.	☐Yes ☐No

4.	Offshore subcontracting arrangement includes all required Medicare Part C and D language such as record retention requirements, compliance with all Medicare Part C and D requirements, etc.	☐Yes ☐No

Part IV. Attestation of Audit Requirements to Ensure Protection of PHI

Item	Attestation	Response
1.	Organization will conduct an annual audit of the offshore subcontractor.	☐Yes ☐No
2.	Audit results will be used by the organization to evaluate the continuation of its relationship with the offshore subcontractor.	☐Yes ☐No
3.	Organization agrees to share offshore subcontractors audit results with Moda Health upon request.	☐Yes ☐No

Signature

By signing below, I attest that I have carefully reviewed the information provided on this Attestation Form and attest to its completeness and accuracy, and that I have the authority to sign this Attestation on behalf of the contractor.

Print Name: _____

Print Title: _____

Signature: _____

Date: _____

Please return document to Moda Health via the email or mailing address listed below:

Email: delegatecompliance@modahealth.com

Mail: Moda Health Plan
Attn: Medicare Compliance Department T-7
601 SW Second Avenue
Portland, Oregon 97204-3156