



Medicare Advantage Offshore Services Attestation

If you are a Quartz contracted provider (also referred to as first tier or downstream entities) using offshore services that involves receiving, processing, transferring, handling, storing, or accessing Quartz Medicare Advantage member PHI, you are required to complete the below information for each entity.

Part I. Offshore Services Information

Offshore entity name:

Offshore entity country or countries, if multiple locations:

Offshore entity address or addresses, if multiple locations:

(The offshore entity address should include the full address for each offshore location, including the country, which will receive, process, transfer, handle, store or access PHI).

Describe offshore functions the offshore entity will perform:

State the proposed or actual effective date of the offshore services:

(The proposed or actual effective date is either the effective date of the Medicare contract with Quartz or the effective date of contract with the entity, whichever is later. The proposed or actual effective date for the services must include the month, date and year. Please use this format: MM/DD/YYYY).

Part II. Precautions for Protected Health Information

Describe the member PHI that will be provided to the offshore entity:

(Please check the boxes to identify the types of PHI the offshore entity may access.)

<input type="checkbox"/> Name	<input type="checkbox"/> Age	<input type="checkbox"/> Date of birth	<input type="checkbox"/> Address	<input type="checkbox"/> Phone number
<input type="checkbox"/> Full SNN	<input type="checkbox"/> Partial SSN (last four)	<input type="checkbox"/> Medicare/HICN	<input type="checkbox"/> Quartz member ID	<input type="checkbox"/> Prescription history
<input type="checkbox"/> Claim history	<input type="checkbox"/> Diagnosis	<input type="checkbox"/> Medical history	<input type="checkbox"/> Banking/financial information	<input type="checkbox"/> Other (provide detailed description)

Explain why providing PHI is necessary to accomplish the offshore services:

Describe any and all alternatives considered to avoid providing PHI. Why was each alternative rejected?

(When describing any alternatives considered to avoid using PHI, be sure to include the reason why the alternative was rejected.)

Part III. Attestation of Safeguards to Protect Beneficiary Information with the Offshore Entity and Audit Requirements to Ensure Protection of PHI

Name of first tier: _____

Offshore entity name: _____

With respect to the offshore services provided by the above-named offshore entity, first tier certifies and attests that:

The agreement it has with the offshore entity requires the offshore entity to have policies and procedure in place to ensure Quartz’s Medicare Advantage Plans’ PHI and other personal information remains secure.

Yes No

The agreement it has with the offshore entity prohibits the offshore entity’s access to Medicare Advantage data not associated with the functions the offshore entity staff performs for Quartz.

Yes No

The agreement with the offshore entity allows the first-tier entity to immediately terminate the offshore services upon discovery of a significant security breach.

Yes No

The agreement with the offshore entity includes all required Medicare Part C and D language. (e.g., record retention requirements, compliance with all Medicare Part C and D requirements, etc.).

Yes No

The first tier will conduct an annual audit or review of its relationship with the offshore entity and monitors offshore staff's access to PHI.

Yes No

The results from the annual audit or review are used to evaluate the continuation of the relationship with the offshore entity.

Yes No

The agreement it has with the entity requires the offshore entity to share audit results with CMS or with Quartz, upon request.

Yes No

First tier agrees to notify Quartz at least 60 days in advance of the first tier's intent to use a new offshore entity or before employing new offshore staff for a function Quartz has asked the first tier to perform.

Yes No

Please provide a brief explanation for any "no" responses for the statements above.

Attestation Authorization

I certify, as an authorized representative of my organization, that the statements made above are true and correct to the best of my knowledge. In addition, my organization agrees to maintain documentation supporting the statement listed above. My organization will produce evidence of the above to Quartz or CMS upon request. My organization understands that the inability to produce this evidence will result in a request from Quartz for a Corrective Action Plan or other contractual remedies, such as contract termination.

First tier organization's authorized representative (Printed name and title)

Signature of first tier organization's authorized representative

Date

First tier organization name (Printed)

Tax ID# or employer ID#

NPI #

First tier organization mailing address

First tier organization's authorized representative phone number and email address

Please return completed form to one of the following:

Email: QuartzFDR@Quartzbenefits.com; or

Fax: (608) 881-8394, Attn: Compliance Department

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