Louisiana

iLinkBlue Service Agreement

THIS AGREEMENT, made and entered into as of the_____day of_____, 20_____, by and between

—LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY, INC.—

(d/b/a BLUE CROSS AND BLUE SHIELD OF LOUISIANA), (hereinafter referred to as "HEALTH PLAN"), a Louisiana corporation domiciled in the Parish of East Baton Rouge, herein represented by its duly authorized and undersigned officer, whose permanent mailing address is declared to be 5525 Reitz Avenue, Baton Rouge, Louisiana 70809, and

Provider Name: _____

Address: _____

City, State, Zip: _____

(hereinafter referred to as "PROVIDER"), and who are the parties to this AGREEMENT and for the consideration and upon the terms and conditions hereinafter expressed, do hereby agree as follows:

Section I Agreement

1.1 HEALTH PLAN grants to PROVIDER access to HEALTH PLAN's iLinkBlue website in accordance with the Terms of Use and Security Policy that is available on the iLinkBlue log-in and welcome screens. PROVIDER understands and agrees that such Terms of Use and Security Policy may be changed by HEALTH PLAN from time to time under HEALTH PLAN's sole discretion, and that PROVIDER will be bound by such terms as a condition of its use of the iLinkBlue website.

1.2 PROVIDER agrees that it shall furnish, supply, configure, maintain, and service all appropriate and applicable personal computer equipment, telecommunication software and hardware, LAN configurations and environments, and Internet connectivity necessary and required to access the electronic services provided by HEALTH PLAN. PROVIDER further agrees that it is responsible for maintaining this computer equipment in proper working condition.

1.3 HEALTH PLAN agrees to provide user instruction manuals and documentation or correspondence, to assist the PROVIDER in the proper use of the iLinkBlue website. HEALTH PLAN shall provide telephone and other PROVIDER support services it deems reasonable, Monday through Friday from 8 a.m. - 4:30 p.m. CST, with the exception of HEALTH PLAN office closure due to announced holidays or any unforeseen circumstances.

Section II Term

2.1 This AGREEMENT is for a term of one year from the service commencement date which is the _____day of___, 20_____. This AGREEMENT will be automatically renewed at the end of each one-year term unless terminated by either party as stated below.

2.2 In order to change any term or condition of this AGREEMENT, except for the Terms of Use and Security Policy mentioned above, HEALTH PLAN shall follow this procedure: HEALTH PLAN must send PROVIDER written notice of any proposed change and the PROVIDER shall have thirty (30) days to reject the proposed change. A rejection of the proposed change by the PROVIDER will terminate this AGREEMENT as of the effective date of the proposed change. Failure of the PROVIDER to reject the proposed change in writing within thirty (30) days of receipt of the notification of change will be considered an acceptance, and the change will be in full force and effect during the remainder of or renewed term of this AGREEMENT.

2.3 HEALTH PLAN or PROVIDER may terminate this AGREEMENT with or without cause, at the end of any calendar month, by giving the other party thirty (30) days prior written notice of termination, the termination to become effective at the end of the next full month.

Section III Warranty

3.1 HEALTH PLAN shall make every effort in accordance with standard business practices to provide uninterrupted access for authorized PROVIDER representatives, but PROVIDER agrees that the service provided by the HEALTH PLAN is without warranty of any kind, either expressed or implied and PROVIDER further assumes the entire risk as to the performance of the HEALTH PLAN.

Section IV General

4.1 PROVIDER acknowledges that all information received or transferred through the iLinkBlue website, including but not limited to an individual's claims, medical histories, diagnoses, and treatments, is confidential and Protected Health Information under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and the requirements of the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 ("HITECH "), and PROVIDER as a Covered Entity bound under such laws, agrees to protect, use and disclose such information only as allowed by law. PROVIDER shall instruct and assure that its personnel, representatives and agents keep such information protected and confidential as required by law. PROVIDER agrees to indemnify and hold harmless HEALTH PLAN from any and all claims, demands, liability, injury, loss, costs, attorney fees, expenses, penalties or any other damages of any nature whatsoever imposed upon or asserted against HEALTH PLAN as a result of any actual or alleged misuse, mishandling or wrongful disclosure of such confidential and Protected Health Information by PROVIDER or PROVIDER's employees, representatives or agents.

4.2 PROVIDER agrees that if any of its employees, representatives or agents knowingly and willfully make or cause to be made a false statement or falsely represent electronic claims or other data transmitted to the HEALTH PLAN, the suspected party shall be subjected to any legal actions in accordance with the applicable State or Federal laws. The PROVIDER must correct any fraudulent or abusive acts. The HEALTH PLAN has the right to recover any overpayments resulting from such acts by PROVIDER, its employees, representatives or agents. The HEALTH PLAN has the right to immediate cancellation of this AGREEMENT should the HEALTH PLAN at any time suspect that such falsification has been committed.

4.3 PROVIDER agrees to abide by the security guidelines set forth and maintained in the user documentation provided by the HEALTH PLAN.

4.4 PROVIDER agrees that the HEALTH PLAN, or its designees, and/or agents of the State or Federal government, have the right, to inspect, examine, copy and conduct on-site audits on source documents related to information transmitted to the HEALTH PLAN and will make those documents available at a reasonable time and place for such inspections. PROVIDER further agrees that it will not charge any fees to the HEALTH PLAN, for any activity related to such inspections and audits.

4.5 PROVIDER shall not assign its master access to the iLinkBlue website or this AGREEMENT to any other person without the prior written consent of HEALTH PLAN. PROVIDER will be responsible for managing and controlling of the access privileges it allows to its employees, representatives and agents at all times, making sure such privileges are duly and timely terminated when its relationship with such employees, representatives and agents end. Any attempt to assign or transfer any of the rights, duties or obligations of this AGREEMENT without HEALTH PLAN's consent is void.

4.6 In the event that PROVIDER contracts with a third party, and the third party's functions requires PROVIDER to grant to that third party access privileges under this AGREEMENT, PROVIDER will notify HEALTH PLAN in writing and cause the third party to execute a Business Associate Agreement compliant with the law. PROVIDER will remain jointly and severally liable to HEALTH PLAN for any acts or omissions of the third party under this AGREEMENT, and the third party must acknowledge in writing that it will agree to be bound to the terms and conditions of this AGREEMENT and any other applicable terms, by executing an addendum to this AGREEMENT to be provided by HEALTH PLAN.

4.7 HEALTH PLAN is not responsible for the failure to render service due to causes beyond its control (including a claim of patent infringement or action thereon) that may inhibit HEALTH PLAN's ability to render service.

4.8 PROVIDER agrees to use coverage/eligibility information only to assist in determining benefits available to HEALTH PLAN'S subscribers and members who receive health care services at the PROVIDER'S facility. PROVIDER acknowledges the information is not a guarantee of payment. HEALTH PLAN shall attempt to keep any and all information updated, as described above or otherwise provided, but makes no guarantee that the information is completely accurate and

true. PROVIDER agrees that it will not hold the HEALTH PLAN responsible for any loss occasioned by the PROVIDER due to inaccurate information provided to the PROVIDER by the HEALTH PLAN. PROVIDER further agrees to hold any and all such information confidential from all third parties who are not otherwise by law or regulation entitled to access such information.

4.9 Any notice or other communication given hereunder shall be in writing and mailed to the appropriate party at the address shown on this AGREEMENT, or to such other address as such parties shall have theretofore designated in writing. Any such notice if mailed properly addressed and postage prepaid shall be deemed given when deposited in the U.S. mails.

4.10 This AGREEMENT constitutes the entire agreement between the parties and supersedes all prior agreements and understandings between them relating to the subject matter hereunder and no modification of this AGREEMENT shall be binding on either party unless it is in writing and signed by both parties.

4.11 This AGREEMENT, and any addendum thereof, is made in the State of Louisiana. All disputes between the parties, including but not limited to those arising from this Agreement, shall be construed in accordance with the laws of the State of Louisiana and the obligations, rights and remedies of the parties hereunder shall be determined in accordance with the laws of the State of Louisiana without giving effect to choice of law or conflict of law rules.

4.12 Each party acknowledges their understanding that the AGREEMENT constitutes a contract between HEALTH PLAN and PROVIDER. HEALTH PLAN is an independent corporation operating under a license from the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield Plans, (the "Association") permitting Blue Cross and Blue Shield of Louisiana to use the Blue Cross and Blue Shield service marks in the State of Louisiana, and that HEALTH PLAN is not contracting as the agent of the Association. PROVIDER further acknowledges and agrees that it has not entered into the AGREEMENT based upon any representation by any person other than HEALTH PLAN and that no person, entity, or organization other than HEALTH PLAN shall be held accountable or liable to PROVIDER for any of HEALTH PLAN'S obligations to PROVIDER created under the AGREEMENT. This paragraph shall not create any additional obligations whatsoever on the part of HEALTH PLAN other than those obligations created under other provisions of the AGREEMENT.

4.13 HEALTH PLAN has adopted a Code of Business Conduct ("Code") which governs the conduct of every employee of HEALTH PLAN and establishes ethical standards for its employees. Certain significant provisions of the Code include conflicts of interest, gifts or gratuities, kickbacks, entertainment, improper payments, and protecting information. A copy of the Code is available to PROVIDER at www.bcbsla.com. PROVIDER agrees to support this Code by avoiding action that could place a HEALTH PLAN employee in violation of this Code.

4.14 The exchange of a copy of a fully executed iLinkBlue Service Agreement by fax or email shall be sufficient to bind all parties to the terms of this AGREEMENT.

THUS DONE AND EXECUTED, effective the date hereinabove setforth.

HEALTH PLAN	**PROVIDER**
Louisiana Health Service & Indemnity Company, Inc. **d/b/a Blue Cross and Blue Shield of Louisiana**	
Authorized signature: Tamara Mayo	Authorized signature: _____
Print name: Tamara Mayo	Print name: _____
Title: Vice President, Provider Reimbursement & Payment Innovation	Title: _____
Date: _____	Date: _____
	Tax-ID #: _____
	NPI #: _____
	Contact name: _____
	Contact phone: _____
	E-mail: _____
	Fax #: _____

Louisiana

Business Associate Addendum to the iLinkBlue Service Agreement

This addendum ("Addendum") is effective upon execution, and amends and is made part of the iLinkBlue Service Agreement ("Agreement") by and between:

Provider Name: _____

Address: _____

City, State, Zip: _____

(hereinafter referred to as **"PROVIDER"**),

Business Associate's Name: _____

Address: _____

City, State, Zip: _____

(hereinafter referred to as **"BUSINESS ASSOCIATE"**), and

Louisiana Health Service & Indemnity Company, Inc.
d/b/a Blue Cross and Blue Shield of Louisiana
5525 Reitz Ave.
Baton Rouge, LA 70809

(hereinafter referred to as **"HEALTH PLAN"**).

WHEREAS, PROVIDER has executed the iLinkBlue Service Agreement with HEALTH PLAN, through which PROVIDER has been given access to HEALTH PLAN's iLinkBlue website.

WHEREAS, PROVIDER has contracted BUSINESS ASSOCIATE to conduct certain administrative services on PROVIDER's behalf, and as part of BUSINESS ASSOCIATE's responsibilities PROVIDER needs to provide BUSINESS ASSOCIATE with access to the iLinkBlue website.

WHEREAS, PROVIDER and HEALTH PLAN are both Covered Entities and the information to be exchanged between BUSINESS ASSOCIATE acting on PROVIDER's behalf and HEALTH PLAN through the iLinkBlue website is confidential and Protected Health Information under the terms of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and the Health Information Technology for Economic and Clinical Health Act, as incorporated in the American Recovery and Reinvestment Act of 2009 ("HITECH"), and their respective regulations and administrative guidance.

WHEREAS, (mark only <u>one</u> box)

☐	PROVIDER will retain control and manage the master access to iLinkBlue for BUSINESS ASSOCIATE.
☐	PROVIDER is delegating the control and management of the master access to iLinkBlue to BUSINESS ASSOCIATE because PROVIDER is not able to conduct such control and management on its own.

WHEREAS, PROVIDER as a Covered Entity under HIPAA certifies that it has executed a Business Associate Agreement with BUSINESS ASSOCIATE which complies with the minimum requirements of HIPAA and HITECH, under which BUSINESS ASSOCIATE has agreed to only use and disclose the Protected Health Information it receives, generates or transmits on behalf of PROVIDER as permitted by law, and PROVIDER further agrees that shall keep such Business Associate Agreement in place and compliant with the law for as long as its relationship with BUSINESS ASSOCIATE lasts.

WHEREAS, BUSINESS ASSOCIATE agrees to assume PROVIDER's responsibilities with HEALTH PLAN under the iLinkBlue Service Agreement for those activities delegated to BUSINESS ASSOCIATE by PROVIDER that involves access and transactions to be performed through the iLinkBlue website.

THEREFORE, PROVIDER, BUSINESS ASSOCIATE and HEALTH PLAN agree as follows:

1. In this Addendum, the terms "Covered Entity", "Electronic Protected Health Information", "Protected Health Information," "Standard", "Trading Partner Agreement", and "Transaction" have the meanings set out in 45 C.F.R. § 160.103. The term "Standard Transaction" has the meaning set out in 45 C.F.R. § 162.103. The term "use" means, with respect to Protected Health Information, utilization, employment, examination, analysis or application within BUSINESS ASSOCIATE. The terms "disclose" and "disclosure" mean, with respect to Protected Health Information, release, transfer, providing access to or divulging to a person or entity not within BUSINESS ASSOCIATE. For purposes of this Addendum, Protected Health Information encompasses Electronic Protected Health Information. Any other capitalized terms not identified here shall have the meaning as set forth in 45 Code of Federal Regulations ("C.F.R.") Parts 160-64 for the Administrative Simplification provisions of Title II, Subtitle F of HIPAA, or in HITECH.

2. The terms of this Addendum will supersede any contradictory contractual agreement between PROVIDER and BUSINESS ASSOCIATE when it relates to the BUSINESS ASSOCIATE's use of the iLinkBlue website on behalf of PROVIDER.

3. BUSINESS ASSOCIATE hereby assumes all obligations and responsibilities that apply to PROVIDER under the iLinkBlue Service Agreement to which this Addendum is incorporated and made a part thereof, for all interactions with HEALTH PLAN through the iLinkBlue portal, including those related to the control and management of the master access credentials to iLinkBlue when such responsibility is delegated by PROVIDER to BUSINESS ASSOCIATE as stated above.

4. This Addendum will apply to any future renewal of the iLinkBlue Service Agreement negotiated by and between PROVIDER and HEALTH PLAN, unless otherwise stipulated between PROVIDER and HEALTH PLAN in writing. PROVIDER will not be able to delegate the negotiation of any renewal or of the terms of the iLinkBlue Service Agreement to BUSINESS ASSOCIATE.

5. PROVIDER and BUSINESS ASSOCIATE certify that they have executed and will keep in place a Business Associate Agreement that at a minimum complies with the following:

    a. BUSINESS ASSOCIATE will be permitted to use and disclose Protected Health Information that it creates or receives on PROVIDER's behalf or receives from HEALTH PLAN (or another business associate of HEALTH PLAN) and to request Protected Health Information on PROVIDER's behalf only as permitted by the Business Associate Agreement between PROVIDER and BUSINESS ASSOCIATE, as long as such use and disclosure is in accordance with the law.

    b. BUSINESS ASSOCIATE will, in its performance of the functions, activities, services, and operations authorized by PROVIDER, make reasonable efforts to use, to disclose, and to request only the minimum amount of Protected Health Information reasonably necessary to accomplish the intended purpose of the use, disclosure or request, except when exempted by law from the minimum necessary limitations.

    c. BUSINESS ASSOCIATE will neither use nor disclose Protected Health Information, except as permitted or required by the Business Associate Agreement or in writing by PROVIDER or as required by law. BUSINESS ASSOCIATE is not authorized to use or disclose Protected Health Information in a manner that will violate the 45 C.F.R. Part 164, Subpart E "Privacy of Individually Identifiable Health Information" ("Privacy Rule") if done by PROVIDER.

    d. BUSINESS ASSOCIATE will develop, implement, maintain, and use appropriate administrative, technical, and physical safeguards to protect the privacy of the Protected Health Information it receives from HEALTH PLAN. The safeguards must reasonably protect the Protected Health Information from any intentional or unintentional use or disclosure in violation of the Privacy Rule, 45 C.F.R. Part 164, Subpart E, and limit incidental uses or disclosures made pursuant to a use or disclosure otherwise permitted by law or the Business Associate Agreement.

    e. BUSINESS ASSOCIATE will develop, implement, maintain, and use administrative, technical, and physical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of Electronic Protected Health Information that BUSINESS ASSOCIATE creates, receives, maintains, or transmits on PROVIDER's behalf as required by the Security Rule, 45 C.F.R. Part 164, Subpart C and as required by HITECH . BUSINESS ASSOCIATE shall also develop and implement policies and procedures and meet the Security Rule documentation requirements as required by HITECH.

    f. BUSINESS ASSOCIATE will require any of its subcontractors and agents, to which BUSINESS ASSOCIATE is permitted by PROVIDER to disclose Protected Health Information, to provide

reasonable assurance, evidenced by written contract, that such subcontractor or agent will comply with the same privacy and security safeguard obligations with respect to Protected Health Information that are applicable to BUSINESS ASSOCIATE under law or the Business Associate Agreement.

g. BUSINESS ASSOCIATE will record the information necessary to account for any legally permissible disclosures it makes of Protected Health Information so that PROVIDER can comply with its obligations under 45 C.F.R. § 164.528. BUSINESS ASSOCIATE must record for each accountable disclosure at least the following: (i) the disclosure date, (ii) the name and (if known) address of the entity to which BUSINESS ASSOCIATE made the disclosure, (iii) a brief description of PROVIDER's Protected Health Information disclosed, and (iv) a brief statement of the purpose of the disclosure. BUSINESS ASSOCIATE shall further provide any additional information to the extent required by HITECH and any accompanying regulations. BUSINESS ASSOCIATE will maintain any information about accountable disclosures for at least 6 years following the date of the disclosure.

h. To the extent agreed to in the Business Associate Agreement, but always as required by law, BUSINESS ASSOCIATE will comply with any request that PROVIDER makes that either (i) restricts use or disclosure of Protected Health Information pursuant to 45 C.F.R. § 164.522(a), or (ii) requires confidential communication about Protected Health Information pursuant to 45 C.F.R. § 164.522(b).

i. BUSINESS ASSOCIATE will make its internal practices, books, and records relating to its use and disclosure of Protected Health Information available to PROVIDER and to the U.S. Department of Health and Human Services to determine BUSINESS ASSOCIATE's and PROVIDER's compliance with the Privacy Rule, 45 C.F.R. Part 164, Subpart E.

6. BUSINESS ASSOCIATE will report to PROVIDER and to HEALTH PLAN any use or disclosure of HEALTH PLAN's Protected Health Information not permitted by the Business Associate Agreement or by law. In addition, BUSINESS ASSOCIATE will report to PROVIDER and to HEALTH PLAN any "Breach" of "Unsecured Protected Health Information" as these terms are defined by HITECH and any implementing regulations. BUSINESS ASSOCIATE shall cooperate with PROVIDER and HEALTH PLAN in investigating the breach and in meeting PROVIDER's and HEALTH PLAN's obligations under HITECH and any other security breach notification laws. Any such report shall include the identification (if known) of each individual whose Unsecured Protected Health Information has been, or is reasonably believed by BUSINESS ASSOCIATE to have been, accessed, acquired, or disclosed during such breach. BUSINESS ASSOCIATE's report will at least:

   a. Identify the nature of the non-permitted access, use or disclosure, including date of the breach and the date of discovery of the breach;

   b. Identify the Protected Health Information accessed, used or disclosed as part of the breach (e.g., full name, social security number, date of birth, etc.);

c. Identify who made the non-permitted access, use or disclosure and who received the non-permitted disclosure;

d. Identify what corrective action BUSINESS ASSOCIATE took or will take to prevent further non-permitted access, uses or disclosures;

e. Identify what BUSINESS ASSOCIATE did or will do to mitigate any deleterious effect of the non-permitted access, use or disclosure; and

f. Provide such other information, including a written report, as PROVIDER may reasonably request.

7. BUSINESS ASSOCIATE will report to PROVIDER and HEALTH PLAN any attempted or successful (A) unauthorized access, use, disclosure, modification, or destruction of Electronic Protected Health Information or (B) interference with BUSINESS ASSOCIATE's system operations in BUSINESS ASSOCIATE's information systems, of which BUSINESS ASSOCIATE becomes aware. BUSINESS ASSOCIATE will make this report upon PROVIDER's or HEALTH PLAN's request, except if any such security incident resulted in a disclosure of Protected Health Information not permitted by the Business Associate Agreement or by law.

8. HEALTH PLAN may terminate this Addendum if it determines, in its sole discretion, that PROVIDER or BUSINESS ASSOCIATE has breached any provision of this Addendum by giving written notice to PROVIDER or BUSINESS ASSOCIATE of the breach. HEALTH PLAN may report such breach to the U.S. Department of Health and Human Services.

9. Upon termination or other conclusion of this Addendum, BUSINESS ASSOCIATE will, if feasible, return to PROVIDER or destroy all of HEALTH PLAN's Protected Health Information in whatever form or medium, including all copies thereof and all data, compilations, and other works derived therefrom that allow identification of any individual who is a subject of Protected Health Information. BUSINESS ASSOCIATE will require any subcontractor or agent, to which BUSINESS ASSOCIATE has disclosed HEALTH PLAN's Protected Health Information to if feasible return to BUSINESS ASSOCIATE (so that BUSINESS ASSOCIATE may return it to PROVIDER) or destroy all Protected Health Information in whatever form or medium received from BUSINESS ASSOCIATE, including all copies thereof and all data, compilations, and other works derived therefrom that allow identification of any individual who is a subject of Protected Health Information, and certify on oath to PROVIDER and HEALTH PLAN that all such information has been returned or destroyed. BUSINESS ASSOCIATE will complete these obligations as promptly as possible, but not later than 45 days following the effective date of the termination or other conclusion of this Addendum.

   BUSINESS ASSOCIATE will identify any of HEALTH PLAN's Protected Health Information, including any that BUSINESS ASSOCIATE has disclosed to subcontractors or agents that cannot feasibly be returned to PROVIDER or destroyed and explain why return or destruction is infeasible. Where HEALTH PLAN agrees that such return or destruction is infeasible, BUSINESS ASSOCIATE will limit its further use or disclosure of such information to those purposes that

make return or destruction of such information infeasible. BUSINESS ASSOCIATE will, by its written contract with any subcontractor or agent to which BUSINESS ASSOCIATE discloses HEALTH PLAN's Protected Health Information, require such subcontractor or agent to limit its further use or disclosure of HEALTH PLAN's Protected Health Information that such subcontractor or agent cannot feasibly return or destroy to those purposes that make the return or destruction of such information infeasible. BUSINESS ASSOCIATE will complete these obligations as promptly as possible, but not later than 45 days following the effective date of the termination or other conclusion of this Addendum.

10. BUSINESS ASSOCIATE's obligation to protect the privacy and safeguard the security of Protected Health Information as specified in this Addendum will be continuous and survive termination or other conclusion of the Business Associate Agreement between PROVIDER and BUSINESS ASSOCIATE, and this Addendum.

11. PROVIDER and BUSINESS ASSOCIATE will indemnify and hold harmless HEALTH PLAN and any HEALTH PLAN affiliate, officer, director, employee or agent from and against any claim, cause of action, liability, damage, cost or expense, including attorneys' fees and court or proceeding costs, arising out of or in connection with any non-permitted use or disclosure of Protected Health Information or other breach of this Addendum by PROVIDER or BUSINESS ASSOCIATE or any subcontractor or agent under PROVIDER's or BUSINESS ASSOCIATE's control.

    If HEALTH PLAN is named a party in any judicial, administrative or other proceeding arising out of or in connection with any non-permitted use or disclosure of HEALTH PLAN's Protected Health Information or other breach of this Addendum by PROVIDER or BUSINESS ASSOCIATE or any subcontractor or agent under PROVIDER's or BUSINESS ASSOCIATE's control, HEALTH PLAN will have the option at any time either (A) to tender its defense to PROVIDER or BUSINESS ASSOCIATE, in which case PROVIDER or BUSINESS ASSOCIATE will provide qualified attorneys, consultants, and other appropriate professionals to represent HEALTH PLAN's interests at PROVIDER's or BUSINESS ASSOCIATE's expense, or (B) undertake its own defense, choosing the attorneys, consultants, and other appropriate professionals to represent its interests, in which case PROVIDER and BUSINESS ASSOCIATE will be responsible for and pay the reasonable fees and expenses of such attorneys, consultants, and other professionals.

    HEALTH PLAN will have the sole right and discretion to settle, compromise or otherwise resolve any and all claims, causes of actions, liabilities or damages against it, notwithstanding that HEALTH PLAN may have tendered its defense to PROVIDER or BUSINESS ASSOCIATE. Any such resolution will not relieve PROVIDER or BUSINESS ASSOCIATE of their obligation to indemnify HEALTH PLAN under this Addendum.

12. If BUSINESS ASSOCIATE conducts in whole or part electronic Transactions on behalf of PROVIDER for which the U.S. Department of Health and Human Services has established Standards, BUSINESS ASSOCIATE will comply, and will require any subcontractor or agent it involves with the conduct of such Transactions to comply, with each applicable requirement of the Transaction Rule, 45 C.F.R. Part 162. BUSINESS ASSOCIATE will not enter into, or permit its subcontractors or agents to enter into, any Trading Partner Agreement in connection with the conduct of Standard Transactions on behalf of PROVIDER that:

    a. Changes the definition, data condition, or use of a data element or segment in a Standard Transaction;

    b. Adds any data element or segment to the maximum defined data set;

    c. Uses any code or data element that is marked "not used" in the Standard Transaction's implementation specification or is not in the Standard Transaction's implementation specification; or

    d. Changes the meaning or intent of the Standard Transaction's implementation specification.

13. Upon the compliance date of any final regulation or amendment to final regulation promulgated by the U.S. Department of Health and Human Services that affects PROVIDER's or BUSINESS ASSOCIATE's use or disclosure of Protected Health Information or Standard Transactions, the Business Associate Agreement and this Addendum will automatically amend such that the obligations imposed on PROVIDER and/or BUSINESS ASSOCIATE remain in compliance with the final regulation or amendment to final regulation.

14. The terms and conditions of this Addendum will override and control any conflicting term of the iLinkBlue Service Agreement. All nonconflicting terms and conditions of the iLinkBlue Service Agreement shall remain in full force and effect.

IN WITNESS WHEREOF, PROVIDER , BUSINESS ASSOCIATE and HEALTH PLAN execute this Addendum in multiple originals to be effective on the last date written below.

PROVIDER

_____
Name of Provider

_____
NPI Number

_____
Authorized Signature

_____
Printed Name

_____
Title

_____
Date

BUSINESS ASSOCIATE

_____
Name of Business Associate

_____
Authorized Signature

_____
Printed Name

_____
Title

_____
Date

HEALTH PLAN

Louisiana Health Service & Indemnity Company, Inc.
d/b/a Blue Cross and Blue Shield of Louisiana

Tamara Mayo
_____
Signature

Tamara Mayo
Printed Name

Vice President, Provider Reimbursement & Payment Innovation
Title

_____
Date

Louisiana

Guide to Completing the EFT Enrollment Form

Blue Cross and Blue Shield of Louisiana requires that participating providers enroll in our electronic funds transfer (EFT) service. EFT allows providers to receive payment directly into their accounts electronically. You can download a copy of the EFT Enrollment Form at www.BCBSLA.com/providers >Resources. The following information should help you complete the form.

1 CONSENT

The consent legally allows Blue Cross to electronically transfer funds to your financial account. The provision for Blue Cross to deduct funds applies when an erroneously credit occurs such as a banking error.

2 PROVIDER INFORMATION

Provider Name – Complete legal name of institution, corporate entity, practice or individual provider

Street Address – The number and street name where a person or organization can be found

City – City associated with provider address field

State/Province – The two character code associated with the state/province/region of the applicable country

ZIP Code/Postal Code – System of postal-zone codes (ZIP stands for “zone improvement plan”) introduced in the U.S. in 1963 to improve mail delivery and exploit electronic reading and sorting capabilities

3 PROVIDER IDENTIFIERS INFORMATION

Provider Federal Tax Identification Number (TIN) / Employer Identification Number (EIN) – A Federal Tax Identification Number, also known as an Employer Identification Number (EIN), is used to identify a business entity.

National Provider Identifier (NPI) – A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted by HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

Group NPI (if applicable) – If part of a provider group, please also report the NPI for your group.

4 PROVIDER CONTACT INFORMATION

Provider Contact Name – Name of a contact in provider office for handling ERA issues

Title – Title of the contact person

Telephone Number – Associated with the contact person

Email Address – An electronic mail address at which the health plan might contact the provider

Fax Number – A number at which the provider can be sent facsimiles

5 RETAIL PHARMACY INFORMATION *(this section should be completed by pharmacies only)*

Pharmacy Name – Complete name of pharmacy

NCPDP Provider ID Number – The NCPDP-assigned unique identification number

6 FINANCIAL INSTITUTION INFORMATION

Financial Institution Name – Official name of the provider's financial institution

Financial Institution Routing Number – The 9-digit identifier of the financial institution where the provider maintains an account to which payments are to be deposited

Type of Account at Financial Institution – The type of account the provider will use to receive EFT payments (e.g. checking, savings, etc.)

Provider's Account Number with Financial Institution – The provider's account number at the financial institution to which EFT payments are to be deposited

Account Number Linkage to Provider Identifier – Choose to enter either the Provider TIN or NPI for the purpose of grouping (bulking) claim payments. Provider preference for grouping (bulking) claim payments must match preference for v5010 X12 835 remittance advice.

7 SUBMISSION INFORMATION

Reason for Submission

- **New Enrollment –** Check to indicate applying for new EFT enrollment

Include with Enrollment Submission

- **Voided Check –** A voided check is attached to provide confirmation of Identification/Account Numbers. Temporary checks are not accepted.

  or

- **Bank Letter –** A letter on bank letterhead that formally certifies the account owners routing and account numbers

Authorized Signature – The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment.

Written Signature of Person Submitting Enrollment – The (usually cursive) rendering of a name unique to a particular person used as conformation of authorization and identity

Printed Name of Person Submitting Enrollment – The printed name of the person signing the form

Submission Date – The date on which the enrollment is submitted

8 RETURN INFORMATION

The form lists the mailing address, fax number and email address of Blue Cross' Network Operations as three options for returning the EFT Enrollment Form.

Mail to: Attn: NAD / BCBSLA
P.O. Box 98029
Baton Rouge, LA 70898-9029

Fax: (225) 297-2750

Email: network.administration@bcbsla.com

Providers should contact their financial institution to arrange for the delivery of the CORE required minimum CCD+ Data Elements necessary for successful re-association of the electronic funds transfer (EFT) payment with the ERA (835) remittance advice. Shown below are the Data Elements that are necessary for re-association:

CCD Record #	Field #	Field Name
5	9	Effective Entry Date
6	6	Amount
7	3	Payment Related Information

Late/Missing EFT and ERA Transactions Resolution Procedures:

ERA (835) files are available weekly in Trading Partner mailboxes on Mondays, and no later than Wednesday, except during holidays or unexpected office closures. If you do not receive your ERA by close of business on Wednesday, you may contact EDI Services at 1-800-216-2583 or email EDIServices@bcbsla.com. Please include the Trading Partner ID, check number, check amount, check date and NPI.

EFT transactions are typically available at the provider's bank on Wednesday. If you have not received your deposit by close of business on Wednesday, you may contact EDI Services by calling 1-800-216-2583.

For questions about the ERA Form, please contact EDI Services at 1-800-216-2583. Also visit www.BCBSLA.com/providers >Electronic Services >Clearinghouse Services.

To check the status of your ERA Form, you may submit your **request** via email to EDIServices@bcbsla.com. Please include the provider or group name, NPI, TIN or EIN and Trading Partner ID. Please allow three to five business days for setup.

To check the status of your EFT Form, you may submit your request via email to network.administration@bcbsla.com. Please include the provider or group name, NPI and TIN or EIN. Please allow up to 15 business days for setup.

Provider's NPI must already be on file with Blue Cross. For more information on reporting your NPI to Blue Cross, you may contact the Provider Data unit of Network Operations at 1-800-716-2299, option 3.

Blue Cross does not set up ERAs for out-of-state providers.

Electronic Funds Transfer (EFT) Enrollment Form

To receive your Blue Cross and Blue Shield of Louisiana payments via electronic funds transfer (EFT), please complete the following information. Be sure to complete a separate Electronic Funds Transfer Enrollment Form for each payment location. Please contact your financial institution to arrange for the delivery of the CORE required minimum CCD+ Data Elements necessary for successful re-association of the electronic funds transfer (EFT) payment with the ERA (835) remittance advice. See Guide to Completing the EFT Enrollment Form for detailed instructions *(included with this form)*.

CONSENT

I hereby authorize Blue Cross and Blue Shield of Louisiana, hereinafter called COMPANY, to initiate credit entries, and in accordance with LSA R. S. 250.38 to initiate adjustment for any credit entries made in error to the account indicated below.

I hereby authorize the financial institution/bank named below, hereinafter call BANK, to credit and/ or debit the same to such account. I am aware that the weekly Provider Payment Register will no longer be mailed to our office, but it will be available for viewing and/or printing in the iLinkBLUE *Provider Suite*.

PROVIDER INFORMATION

Provider Name		
Provider Address: Street		
City	State/Province	Zip Code/Postal Code

PROVIDER IDENTIFIERS INFORMATION

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)	
National Provider Identifier (NPI)	Group NPI (if applicable)

PROVIDER CONTACT INFORMATION

Provider Contact Name	Title	
Telephone Number	Email Address	Fax Number

RETAIL PHARMACY INFORMATION

Pharmacy Name
NCPDP Provider ID Number

FINANCIAL INSTITUTION INFORMATION

Financial Institution Name		
Financial Institution Routing Number	Type of Account at Financial Institution	Provider's Account Number with Financial Institution

Account Number Linkage to Provider Identifier

- ❑ Provider Tax Identification Number (TIN): _____
- ❑ National Provider Identifier (NPI): _____

~Over~

SUBMISSION INFORMATION

Reason for Submission

- ❑ New Enrollment

Include with Enrollment Submission

- ❑ Voided Check *(temporary checks are not accepted)*

  or

- ❑ Bank Letter

Authorized Signature

This information is to remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and BANK a reasonable opportunity to act on it. An EFT Termination/Change Form must be completed if **any** of the above information changes.

_____
Written Signature of Person Submitting Enrollment

_____
Printed Name of Person Submitting Enrollment

_____
Submission Date

RETURN INFORMATION

Please return your completed Electronic Funds Transfer Enrollment Form in one of the following ways:

Mail to: Attn: NAD/BCBSLA
P.O. BOX 98029
Baton Rouge, LA 70898-9029

Email: network.administration@bcbsla.com

Fax: (225) 297-2750

If you have any questions about this form or your EFT enrollment status, please contact Network Operations at:

Phone: (800) 716-2299, option 3

Email: network.administration@bcbsla.com

For internal use only: *iLB set up complete.*

☐

Louisiana

Instructions for Accessing Our Secure Online Services

Blue Cross offers many online services that require secure access. Blue Cross requires that each provider organization must designate at least one administrative representative to self-manage user access to our secure online services. These services include applications such as:

- iLinkBlue
- BCBSLA Authorizations
- Behavioral Health Authorizations
- Pre-Service Review for Out-of-Area Members (for BlueCard® members)
- and more (as we develop new services)

To Report Your Administrative Representative to Blue Cross:

1. Determine who at your organization should be an administrative representative.
2. Complete the Administrative Representative Registration Form that includes the Acknowledgment Form (on the following pages). Send completed documents to our Provider Identity Management Team.

   Email: PIMTeam@bcbsla.com

   Fax: 1-800-515-1128
   Attn. Provider Identity Management

   Mail: BCBSLA - Provider Identity Management
   P.O. Box 98029
   Baton Rouge, LA 70898-9029
3. Once your administrative representative is set up, we will send an email with detailed instructions on how to log into our Security Setup Tool.

Need Help?

If you have questions regarding the administrative representative setup process, please contact our Provider Identity Management Team.

Email: PIMTeam@bcbsla.com
Phone: 1-800-716-2299, option 5

What is an Administrative Representative?

- A person designated to serve as the key person for delegating access to our secure online services to appropriate users for the provider
- A person who agrees to adhere to Blue Cross' guidelines
- A person who will only grant access to those employees who legitimately must have access in order to fulfill their job responsibilities
- A person who promptly terminates employee access when an employee changes roles or terminates employment

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Administrative Representative Registration Form

Complete this form for each administrative representative at your organization. Please include the information for the provider the administrative representative is servicing, as well as contact information for both the administrative representative and the administrative representative's manager.

GENERAL PROVIDER INFORMATION		
Practice or Facility Name		
Address		
Phone Number	National Provider Identifier (NPI)	
Tax ID	Is the Behavioral Health Authorizations Application needed?	
ADMINSTRATIVE REPRESENTATIVE INFORMATION		
Administrative Representative Name	Title	Date of Birth
Contact Phone Number	Email Address	
Additional Phone Number	Additional Email Address	
Is the administrative representative also an iLinkBlue user?		
MANAGER/OWNER INFORMATION		
Manager/Owner's Name *(other than the administrative representative)*	Title	Date of Birth
Contact Phone Number	Email Address	

Return Form To:

Email: PIMTeam@bcbsla.com

Fax: 1-800-515-1128
Attn. Provider Identity Management

Mail: BCBSLA - Provider Identity Management
P.O. Box 98029
Baton Rouge, LA 70898-9029

Louisiana

Administrative Representative Acknowledgment Form

I understand that I have been designated by my employer as the Administrative Representative for our organization for the purpose of granting access only as required to Blue Cross and Blue Shield of Louisiana (BCBSLA) secure online services. As such, I am responsible for delegating access to appropriate users within my organization and adhering to BCBSLA's guidelines regarding this delegation.

I agree that access will be granted only to those employees who legitimately must have access in order to fulfill their job responsibilities and only when indicated by BCBSLA's guidelines. I am also responsible for terminating employee access to BCBSLA's secure online services, as applicable and at such time as the employee changes roles or terminates employment with my organization. I agree to implement procedures that will ensure that such terminations will be addressed promptly in accordance with the information outlined in BCBSLA's Security Setup Guide.

As the Administrative Representative, I understand that secure online services are assets of BCBSLA. Any misuse, personal use or use of these assets for any business other than which I am authorized to perform is strictly prohibited and may be subject to criminal prosecution under federal and state laws. I must at all times, respect the confidentiality of all member (patient) information or data that I am working with or may have access to on the BCBSLA system. In addition, I am obligated to protect these assets by maintaining complete secrecy over my Login ID and Password. Under no conditions can I reveal these to anyone or allow anyone else use of the system under my Login ID. I understand that if my role in the organization changes or if my term of employment ends with my current organization, it is my responsibility to contact my employer and let him or her know that my duties and access as Administrative Representative must terminate as well. My employer shall notify BCBSLA immediately of any breach of confidentiality.

It is my responsibility to report any fraud, suspected fraud or abuse, or privacy or confidentiality concerns related to BCBSLA assets to my employer (Hospital or Clinic management) and to BCBSLA. I further understand that BCBSLA monitors the system and any case where abuse is detected will be reported to my management and may result in either the loss of access for my Logon ID and/or legal action.

This Acknowledgment may be validly executed via facsimile transmission or through other electronic means showing the signature of the party and each such reproduced copy of this Acknowledgment shall constitute an original Acknowledgment for all purposes. Administrative Representative agrees that a facsimile or electronic scanned copy of this document with facsimile or scanned signatures may be treated as an original and will be admissible as evidence in a court of law.

Note: Login ID's with no sign on activity for 90 days will automatically be disabled. Administrative Representatives will be required to create a new password in order to reactivate their Login ID.

By signing my name in the blank below and completing the information required on this Acknowledgment, I certify that I understand and agree to the responsibilities outlined above.

Print name of Administrative Representative

Signature of Administrative Representative

Date

Print name of Manager

Signature of Manager

Date

Tax ID