

DHCS Employee Approver Certification

DHCS Approved (DHCS use only)	
<u>Date</u>	<u>Approver</u>

For Access to Confidential DHCS Drug Medi-Cal

DHCS Branch : _____

To ensure the confidentiality of Drug Medi-Cal (DMC) data, the Department of Health Care Services (DHCS) requests the appropriate DHCS Manager designate a primary and a secondary contact to be responsible for approving employee requests for access to confidential patient data in the Short-Doyle/Medi-Cal claims system. Please provide this information in the spaces below and fax this form to (916) 323-0653. If you have any questions about this form, please call (916) 323-2043.

Primary 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/ITWS users)	

Secondary 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/ITWS users)	

DHCS Certification:

As Manager of _____, I designate the above individuals to have
 (unit name)
 independent authority to approve access requests to specific confidential Drug Medi-Cal data. The DHCS may rely on approvals, denials, and changes made by these individuals in its processing of access requests to the Short-Doyle/Medi-Cal claims system. As changes occur to the above approving contact's information (name, phone, e-mail or system), I will sign an updated certification and forward it to DHCS ITWS. Also, I acknowledge reading the Confidentiality Statement for all DHCS AOD users of the ITWS.

 Manager (signed and printed) _____
 Date