DELTA DENTAL

Northeast Delta Dental
One Delta Drive
PO Box 2002
Concord, NH 03302-2002
603-223-1000

Fully Insured Group Authorization for Use of Group Admin Portal

Access to the portal is for the use and disclosure of PHI

Group Name: _____ Dental and/or DeltaVision Group # _____

The Group hereby designates the following employees and/or producer/agency or consultants to represent the group in order to carry out Group Dental and/or Vision Plan functions that may involve the use and disclosure of Protected Health Information (PHI) on behalf of the Group:

GROUP – Enter name of individual(s) below:	Check off RELATIONSHIP TO GROUP		Enter Individual's EMAIL (No department emails)	Type of ACCESS requested
	☐ Group Administrator ☐ Eligibility	☐ Human Resources ☐ Cobra Administrator ☐ Enrollment TPA		☐ Read Only ☐ Read & Write (make changes)
	☐ Group Administrator ☐ Eligibility	☐ Human Resources ☐ Cobra Administrator ☐ Enrollment TPA		☐ Read Only ☐ Read & Write (make changes)
	☐ Group Administrator ☐ Eligibility	☐ Human Resources ☐ Cobra Administrator ☐ Enrollment TPA		☐ Read Only ☐ Read & Write (make changes)
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	☐ Group Administrator ☐ Eligibility	☐ Human Resources ☐ Cobra Administrator ☐ Enrollment TPA		☐ Read Only ☐ Read & Write (make changes)
Enter Producer and/or AGENCY name:	**Check off RELATIONSHIP TO GROUP**		**Enter Individual's EMAIL**	**Type of ACCESS requested**
	☐ Producer/Consultant	☐ Cobra Administrator ☐ Enrollment TPA		☐ Read Only ☐ Read & Write (make changes)
	☐ Producer/Consultant	☐ Cobra Administrator ☐ Enrollment TPA		☐ Read Only ☐ Read & Write (make changes)
	☐ Producer/Consultant	☐ Cobra Administrator ☐ Enrollment TPA		☐ Read Only ☐ Read & Write (make changes)

Authorization: An Authorization for Release of Protected Health Information is required for questions regarding individual claims, eligibility, or benefit information.

The Group Admin Portal is an online portal used to enroll and update a subscriber's and/or dependent's eligibility status.

The above designations and the below authorization will remain in effect until revoked or changed by the Group in writing and will be relied upon by Northeast Delta Dental. Notify Northeast Delta Dental immediately in writing of any changes.

Duly Authorized Group Representative/Administrator: _____ Date _____

Print Name and Title _____

Email _____ Phone _____

Sign and email form to: ***groupadminportal@nedelta.com*** *or fax to:* ***603-223-1129***