Assist Point

PRIOR AUTHORIZATION SUPPORT AGREEMENT

This Prior Authorization Support Services Agreement ("Agreement") is entered into as of _____ ("Effective Date") by and between **Assist Point** ("Service Provider") and _____, a medical practice/doctor's office ("Practice").

1. Purpose and HIPAA

- The Practice is a HIPAA covered entity and engages Assist Point to help with prior authorizations ("PAs") for its patients.
- Assist Point is a HIPAA business associate and will only use patient information as needed to perform PA work and as allowed by law.
- Assist Point will protect patient information with reasonable security measures and will report any known unauthorized use or disclosure.

2. Services – Choose One Option

Check **one** option:

☐ **Option 1 – Start PA Only**

- Service Provider will only initiate the PA request and notify the practice via phone, fax or any electronic methods such as CoverMyMeds.
- The Practice is responsible for all follow-up with the payer, including phone calls, extra information, appeals, and confirming final approval or denial.

☐ **Option 2 – ePA as Delegated Representative**

- Assist Point prepares and submits PAs through electronic prior authorization (ePA) systems and payer portals using information from the Practice.
- Assist Point may contact payers directly about PA status and questions, as the Practice's delegated representative, when allowed by the payer.
- The Practice stays responsible for medical decisions, the accuracy of all clinical information, and reviewing final PA decisions. Assist Point does not guarantee approval.

3. Practice Responsibilities

- Provide accurate and complete clinical and insurance information needed for PAs.
- Respond promptly to Assist Point's questions or requests for more information.
- Remain fully responsible for patient care, medical necessity, and communicating decisions to patients.

4. PHI at the End of the Relationship

- When this relationship ends, Assist Point will return or destroy patient information it received from the Practice if the Practice asks and if it is reasonably possible.
- If the law requires Assist Point to keep some information, it will continue to protect it under this Agreement.

SIGNATURES

(If the prescribing practitioner is not signing this form, I acknowledge that I have authority to sign on their behalf)

Practice (Covered Entity):
Name of Practice: _____
By (Authorized Signatory): _____
Title: _____
Signature: _____
Date: _____

Assist Point (Service Provider):
By (Authorized Signatory): _____Vilma Garcia _____
Title: Prior Authorization Specialist_____
Signature: _____
Date: _____
Email: Lvreferrals@assistpoint.co
P/F: 702-551-5212

Prescriber Name	NPI Number