

Contract #: _____

CONTRACT ROUTING SHEET

Date Prepared: 5-7-6

Need Date: 5-8-7 (if possible)

PROCESSING DEPARTMENT:

Department: Human Resources
 Dept. Contact: Sherril Jodar
 Phone #: 5597
 Department: Human Resources
 Authorization: _____

CONTRACTOR:

Name: Blue Shield
 Address: _____
 Phone: _____

CONTRACTING DEPARTMENT: Human Resources


Service Requested: Review of Medical Coverage Contract – Blue Shield TPA and Hipaa amendment #1

Contract Term: Annual Contract/Amendment Value: \$600,000

Compliance with Human Resources requirements? Yes: X No: _____

Compliance verified by: _____

COUNTY COUNSEL: (Must approve all contracts and MOU's)

Approved: _____ Disapproved: _____ Date: 5/14/07 By: 
 Approved: _____ Disapproved: _____ Date: _____ By: _____

ASSIGNMENT
 DATE 05/07/2007
 ATTORNEY MIKE G
 DEPT./INDEX NO. CR 4110
 BY: JMO

PLEASE FORWARD TO RISK MANAGEMENT – attention Sherril Jodar. THANKS!

RISK MANAGEMENT: (All contracts and MOU's except boilerplate grant funding agreements)

Approved: Yes Disapproved: _____ Date: 5-7-7 By: S. Jodar
 Approved: _____ Disapproved: _____ Date: _____ By: _____

RECEIVED
 HUMAN RESOURCES DEPT
 07 MAY 15 PM 1:27

OTHER APPROVAL: (Specify department(s) participating or directly affected by this contract)

Departments: _____
 Approved: _____ Disapproved: _____ Date: _____ By: _____
 Approved: _____ Disapproved: _____ Date: _____ By: _____