CONFIDENTIALITY AGREEMENT FOR RECEIPT OF CMS UNIQUE ID – SHIP

I, _____, hereby agree and understand that I am accountable for protecting the privacy and confidentiality of the information that is disclosed to me pursuant to my use of the CMS Unique ID which has been assigned to me by the Centers for Medicare & Medicaid Services (CMS). This ID, along with other identifying information will allow a 1-800-MEDICARE customer service representative (CSR) or participating Medicare Advantage or Part D Plan sponsors to disclose certain beneficiary eligibility and information specific to claims payments to me for the purpose of assisting the beneficiary. I further understand this CMS Unique ID is to be confidential, and I am not to disclose this CMS Unique ID to anyone other than the CSR or participating plan representative. I attest that I have received and reviewed privacy and confidentiality training.

SIGNATURE – Unique ID User	Date Signed

State SHIP or SMP Director Completes this Section

SIGNATURE – SHIP or SMP Director	Date Signed

DISTRIBUTION: Original – file; Copy – Unique ID user