

CONFIDENTIALITY AGREEMENT FOR RECEIPT OF CMS UNIQUE ID

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 claims payment-specific information 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.

Unique ID User:

Signature

Date

State SHIP or SMP Director completes this section:

Signature

Date

Program Generating and Managing This User’s Unique ID (Choose Only ONE):

- STARS (SHIP)
- SIRS (SMP)

Original to File
Copy to Unique ID User