

Confidentiality Agreement for Receipt of the State Health Insurance Assistance Program (SHIP) Unique ID

I, _____, acknowledge that I have been issued a SHIP Unique ID by the Centers for Medicare and Medicaid Services (CMS) and I hereby agree to and understand the following terms:

- The SHIP Unique ID allows me to discuss and/or obtain information on behalf of Medicare beneficiaries, without the beneficiary being present.
- I am accountable for protecting the privacy and confidentiality of the information that is disclosed to me pursuant to my use of the SHIP Unique ID.
- The SHIP Unique ID, along with other identifying information, will allow customer service representatives (CSRs) at 1-800-Medicare and/or participating Medicare Advantage or Part D Plan sponsors, to disclose information related to beneficiary eligibility and claims payments so that I am able to assist the beneficiary.
- The SHIP Unique ID is confidential, and I am not to disclose this ID to anyone other than the CSRs at 1-800-Medicare and/or participating Medicare Advantage or Part D Plan sponsors.
- If I disclose my SHIP Unique ID to anyone and/or use it for purposes other than for what it is intended, my permissions will be terminated.
- It is my responsibility to remain a registered and active user in the SHIP Tracking and Reporting System (STARS) by reporting activities on monthly basis.
- If I fail to actively report beneficiary counseling activity at least once, every 120 days, STARS will automatically inactivate my SHIP Unique ID.
- I have received, reviewed, and completed the annual HIICAP exam and privacy training.

SHIP Unique ID User Signature

Date

Agency

County HIICAP Coordinator Signature

Date

New York State SHIP Director/Coordinator Signature

Date