Confidentiality Agreement for receipt of 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 SHIP Unique ID, which has been assigned to me by the Centers for Medicare & Medicaid Services. 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 sponsor to disclose certain beneficiary eligibility and claims payment-specific information to me for the purpose to assist the beneficiary. I further understand:

- My Unique ID is to remain confidential.
- I am not to disclose My Unique ID to anyone other than the CSR.
- Confidentiality breach is grounds for immediate dismissal.

Counselor name (print) ____________________________ Date (MM/DD/YYYY) ____________________________

Counselor name signature ____________________________ County name (print) ____________________________

Counselor email address (for SHIBA use only) ____________________________

Email signed form to: shiba@oic.wa.gov

***For SHIBA Program Office use only***

☐ Path to Certification complete.
☐ Confidentiality and privacy training complete.
☐ Confidentiality and privacy training assessment (Passing score: >=80%).

SHIP director signature ____________________________ Date (MM/DD/YYYY) ____________________________

Rev. 08/01/2020