



MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

BREAST AND CERVICAL CANCER DIAGNOSIS AND TREATMENT PROGRAM

eCMS User Agreement and Information Form

I _____ agree to use the eCMS system for the intended business purpose of submitting and tracking claim payments. I will secure the logon and password in a safe place.

For EDI also use form: https://www.dhmheclaims.org/bccdt/pdf/BCCDT_Companion_Guide.pdf

Fed Tax ID: _____ Store #/Suffix: _____

Printed Name: _____

Company: _____

Suite/Room: _____

Address: _____

City: _____

State/Zip: _____

E-Mail Address: _____

Phone Number: _____

Claims Submission Type: Portal _____ EDI _____ Both _____

For security purpose you must answer the following questions. These questions will be used to verify that we are talking to the authorized user when requesting help with your password.

1. What is your mother's maiden Name? _____
2. Where were you born? _____
3. What is your favorite color? _____

For my own protection I will notify you when I leave employment with this company or my job duties change and I am no longer responsible for claims submission or tracking.

Signature: _____ Date: _____

This form must be mailed back to the following address:

Family Health Administration – DHMH
Attn: Jacqueline Richter, R.N., BSN; Program Manager
Center for Cancer Surveillance & Control
P.O. Box 13528
Baltimore, MD 21201
<http://dhmheclaims.org>

Questions? Call: 410-767-6787