



## Department Of Health and Mental Hygiene

### Kidney Disease 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 my password in a safe place.

Federal Tax ID: \_\_\_\_\_ Store #/Suffix: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Company: \_\_\_\_\_

Suite/Room \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State/Zip: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

For security purposes, 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:

Kidney Disease Program of Maryland  
201 W. Preston Street  
Room SS-3  
Baltimore, MD 21201  
<http://dhmheclaims.org>