CERTIFICATION FOR REUSE OF CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) DATA

By signing this document, you are certifying that the individuals identified in the file attached or data set name(s) provided were obtained from the **original** CMS data file(s) disclosed to:

Organization ____
Contact Person____
Title ____
Street Address ____
____
City/State/Zip Code____
Phone Number/FAX Number ____
E-Mail Address____
DUA Number(s)____

Please indicate the information being provided:

___ Finder file (electronic list of Health Insurance Claim account numbers in positions 1-11)
___ Data Set Name(s): ____
____
____
____

The undersigned individual hereby attests that he or she is certifying that the above information and file information are accurate (to be completed by the Organization requesting reuse of data):

____
(Name and Title of Requestor)

____
(Company/Organization)

____
(Street Address)

____
(City/State/Zip Code)

____
(Phone Number – Including Area Code and E-Mail Address)

____
(Signature)

Sample Format of Finder File

Supply Health Insurance Claim (HIC) numbers on diskette or CDROM in the following format and press return after each entry. Please **label diskette** or **CDROM** with **filename**, **number of records** and **DUA number**:

Field Name	Field Size	Location
HIC	11	1-11

Send To:

Director, Division of Privacy Compliance Data Development
Centers for Medicare & Medicaid Services
OIS/EDG/DPCDD
7500 Security Boulevard
Mailstop: N2-04-27
Baltimore, MD 21244-1850