



Medicare Advantage - Prescription Drug Fraud, Waste, and Abuse Training Attestation Form

I attest that I have completed Fraud, Waste, and Abuse training as mandated by the Centers for Medicare & Medicaid Services (CMS):

CHECK ONE:

I reviewed the Community Health Plan Fraud, Waste, and Abuse presentation on: _____
(Month/Day/Year)

OR

I completed training offered by _____ Health Plan on _____
(Health plan or company providing training)
(Month/Day/Year)

I understand that CMS and/or health plans may request additional information to substantiate the statements made in this attestation.

Please submit the following information which is required for tracking purposes

First Name:			
Last Name:			
or Group Name:			
Address:			
City:			
State:		Zip Code:	
Phone Number:			
NPI Number:			
License Number:			

Health Plan Submission Information

(Completed forms may be submitted via mail, email or by facsimile transmission.)

Community Health Plan
Attn: Compliance Officer
720 Olive Way, Suite 300
Seattle, Washington 98104
Fax: 206-652-7020
Email: Compliance.Officer@chpw.org