COMMUNITY HEALTH PLAN of Washington™

GENERAL COMPLIANCE AND FRAUD, WASTE, AND ABUSE (GCFWA) TRAINING ATTESTATION FORM FOR HEALTH CARE PROVIDERS

Community Health Plan of WA (CHPW) is required by contract with the Centers for Medicare & Medicaid Services (CMS) and the Washington State Health Care Authority (HCA) to ensure its contracted provider network completes General Compliance and/or Fraud, Waste, and Abuse (FWA) Training within 90 days of contract and annually thereafter. CHPW is required to maintain evidence that their contracted providers have completed training.

CMS requires that you complete the attestation form, attesting that training requirements have been met. In the event of an audit, you must maintain individual training documentation for you, your staff, and subcontractors. Training documentation may include sign-in sheets, attestations, and electronic certifications.

As stated by CMS, there is one exception to the **FWA** training and education requirement as follows:

Regulations effective June 7, 2010 implemented a "deeming" exception which exempts Providers who are enrolled in Medicare Part A or B from annual FWA training and education. Therefore, if an entity or an individual is enrolled in Medicare Part A or B, FWA training and education is already satisfied; ***and this Attestation would only apply to General Compliance***.

Important Update: CMS **suspended** (until further notice) the requirement that would have been effective January 1, 2016, where Providers must use General Compliance Training and FWA (GCFWA) Training courses available at www.cms.gov/MLNProducts. *Please note that your training courses must meet CMS standards and requirements and should mirror the content on the MLN training course.*

I, the undersigned, attest that I am an authorized representative with signature authority for the organization or group listed below and that all employees and downstream entities that provide health or administrative services for CHPW members at or on behalf of my organization have completed General Compliance and/or Fraud, Waste and Abuse training as required by CMS.

Facility/Clinic/Provider Information – ***all fields below must be completed – to avoid processing delays, please type or print legibly.***

Entity Name:		**Tax ID#** (*if you have multiple tax IDs, list your primary*):
Address:		**Suite #:**
City:	**State:**	**Zip Code:**
Phone Number:	**Fax Number:**	**E-mail:**
Authorized Representative (Print):		**Title:**

My signature certifies that the information provided here is true and correct. I understand that CMS, HCA, and/or CHPW may request additional information to substantiate our Attestation.

Signature:	**Date:**

Submission Information:

Submit completed forms via:
Fax: 206-613-5018, ATTN: PROVIDER RELATIONS
E-mail: Send a scanned copy to Provider.Relations@chpw.org
USPS: Community Health Plan of Washington, C/O Provider Relations, 1111 Third Avenue, Ste. 400, Seattle, WA 98101

For questions about this form, please refer to our FAQs and instructions at http://chpw.org/resources/GCFWA_Instructions_FAQs_010116.pdf or email your questions to Provider.Relations@chpw.org and a Provider Relations representative will respond promptly. Thank you.