

**Providence Health Plan Provider Certification of Compliance with the Medicare Part C and Part D Fraud Waste and Abuse and Compliance Training Requirements**

**Certification Summary**

This Certification of Compliance is for providers participating in Providence Health Plan Medicare Advantage/Prescription Drug network. By completing and storing this document, the contracting provider attests and certifies that the Medicare Advantage/Part D specialized training required of downstream entities has been completed in compliance with the requirements referenced below.

**Attestation Statement**

By completing and storing this Certification, practice or entity certifies as follows:

All persons (including its employees and contractors and subcontractors) involved in administering or delivering Medicare Advantage/Part D Drug benefits within its organization have completed Medicare Advantage/Part D Compliance/ Fraud, Waste and Abuse (FWA) training, as required by 42 C.F.R. § 423.504 (b)(4)(vi)(C). Individuals who have responsibilities in Medicare Advantage/Part D business areas receive specialized training on issues posing compliance risks unique to their job functions, both at initial hire, at time of contract (if a contractor or subcontractor), when requirements change, and at least annually as a condition of continued employment or contract.

Providence Health Plan has made training available to the entity for its employees, contractors and subcontractors, or the entity has elected to complete a comparable Medicare Advantage/Part D Compliance/FWA training program that complies with the above requirements. As a result of such training, practice or entity is informed about the Medicare Advantage/Part D program, and more specifically, about the following:

- Information about the various laws and regulations related to FWA;
- How to detect, prevent and correct FWA; and,
- How and where to report potential FWA violations

Practice or entity agrees to maintain copies of attestations and/or training logs and make them available to Providence Health Plan and/or CMS upon request. Provider hereby attests on behalf of the practice or entity to the foregoing and certifies all required training has been completed.

**Please check only one:**

- I have completed the Providence Health Plan Fraud, Waste and Abuse Training on this date \_\_\_\_\_.
- I am signing on behalf of my organization that we have completed the Providence Health Plan Fraud, Waste and Abuse Training and comply with the statements above on this date \_\_\_\_\_.
- I have completed the required Fraud, Waste and Abuse Training provided by \_\_\_\_\_ on this date \_\_\_\_\_.  
*(name of entity)*
- I am signing on behalf of my organization that we have completed the required Fraud, Waste and Abuse Training provided by \_\_\_\_\_ and comply with the statements above on \_\_\_\_\_  
*(name of entity)*  
this date \_\_\_\_\_.

Provider Name or Authorized Signer

Date

\_\_\_\_\_

\_\_\_\_\_