



## Medicare Advantage - Prescription Drug

### Fraud, Waste and Abuse Training Group Attestation Form

I attest that I am an authorized representative who has signature authority for the organization or group listed below and that each of the providers and staff persons included in the excel file submitted with this form have authorized me to attest on his or her behalf and each has completed Fraud, Waste and Abuse training on or before December 31, 2009 as mandated by the Centers for Medicare & Medicaid Services (CMS).

I understand that CMS and/or health plans may request additional information to substantiate the statement made in this attestation and the accompanying excel file that lists employees of this organization that have completed training.

Organization Name: \_\_\_\_\_

Tax ID Number: \_\_\_\_\_

Authorized Representative (print name): \_\_\_\_\_

(signature): \_\_\_\_\_

Title: \_\_\_\_\_

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

Email: \_\_\_\_\_

Date: \_\_\_\_\_

Please return this completed attestation form and an excel spreadsheet listing all providers and staff that have completed training to each Medicare Advantage – Prescription Drug health plan in which you have a contract using the information on page 2. The standard excel file format that must be submitted along with this form is available at <http://www.hcasma.org/MedicalTraining.aspx>.

It is the responsibility of providers and staff to complete the required Medicare training and attest to health plans and CMS regarding the same, and HCAS disclaims any responsibility for making or communicating such attestations.

**Excel File Format:**

<b>Field Name</b>	<b>Field Description</b>	<b>Standard Format Requirements</b>
First Name	Provider or staff first name	Text
Last Name	Provider of staff last name	Text
Organization Name	Organization name	Text
Address Line 1	Primary practice address line 1	Text
Address Line 2	Primary practice address line 2	Text
City	Primary practice city	Text
State	Primary practice state	Standard State abbreviations
Zip	Primary practice zip	Text
NPI #	Individual provider's NPI #  If not a provider, include "9999" in the space provided	Text
License #	Individual provider's state medical license #  If not a provider, include "9999" in the space provided	License # only. Do not include state abbreviations proceeding number
Tax ID#	Provider's tax ID#	Text
Date Training completed	Date the training program was completed	mm/dd/yyyy
Location of Training	Name of training program (ex. HCAS or include name of alternate training program completed)	Text

**Health Plan Submission Information:**

<b>Blue Cross Blue Shield of MA</b>  <a href="mailto:Cynthia.Carriveau@bcbsma.com">Cynthia.Carriveau@bcbsma.com</a>	<b>Fallon Community Health Plan</b>  <a href="mailto:askfchp@fchp.org">askfchp@fchp.org</a>
<b>Health New England</b>  <a href="mailto:fwaptraining@hne.com">fwaptraining@hne.com</a>	<b>Harvard Pilgrim Health Care</b>  <a href="mailto:Michael.Comerford@harvardpilgrim.org">Michael.Comerford@harvardpilgrim.org</a>
<b>Tufts Health Plan</b>  <a href="mailto:Rosemary_Brown@tufts-health.com">Rosemary_Brown@tufts-health.com</a>	