Medica

Provider Attestation of Compliance with Required Compliance and Fraud, Waste, and Abuse Training

☐ 1. Please check the box if your organization does ***not*** serve Medicare or Medicaid patients and is exempt from this requirement.

☐ 2. Please check the box if your organization serves ***only*** Medicaid and/or commercial patients.

☐ 3. Please check the box if your organization has a Medicare Certification Number and is exempt from fraud, waste and abuse (FWA) attestation but did complete the General Compliance training, Standards of Conduct, and compliance policies and procedures (provide Medicare # below).

If you marked boxes 1, 2 or 3 above, please do not fill out the remainder of the form beyond the bold line. Please provide the name of your organization or representative and Medicare or Medicaid numbers if applicable. Please return this form to Medica using one of the methods noted at the end of this form.

______________________________	______________________________	______________________________
Print name of organization or representative	Organization (legal entity name)	Date signed

Medicare #______________________ Medicaid ID #____________________

If you *did not* mark the boxes above, please fill out the section below. By signing below, I attest that my organization, and all employees (including temporary workers and volunteers), board members, and first tier, downstream and related entities (FDRs) have read and agree to comply with:

(i) all written compliance policies and procedures and standards of conduct meet requirements set forth by Medica;
(ii) fraud, waste and abuse training requirements are in accordance with federal guidelines; and
(iii) general compliance training requirements are in accordance with guidelines set by Chapter 42 of the Code of Federal Regulations, Parts 422.503 and 423.504

I am authorized to bind the entity and I attest that the above information is true and correct. I will notify Medica of any changes to this information.

____
Print name of organization, representative or individual name

____
Organization (legal entity name)

____
Representative or individual's title

____
Date signed

____
Signature

[Site ID]

Please return this form to Medica through one of the following means: (a) emailing a scanned copy of the completed and signed form to providercertifications@medica.com or (b) mailing the form to Medica Health Plans, Mail Route CP425, P.O. Box 9310, Minneapolis, MN 55440-9310. If you have any questions, please call 1 (800) 458-5512, or send an email to the above email address.

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