ANNUAL NETWORK PROVIDER ANTI-FRAUD, WASTE & ABUSE TRAINING ACKNOWLEDGMENT & ATTESTATION

Health Plan of San Joaquin/Mountain Valley Health Plan (HPSJ/MVHP), as a licensed health care services plan regulated by the Department of Managed Health Care (DMHC) and contracted with the Department of Health Care Services (DHCS), is committed to protecting members, our network of providers, and public interests by preventing, detecting, investigating, correcting, and reporting Fraud, Waste, and Abuse (FWA).

Under legal requirements overseen by the federal Centers for Medicare & Medicaid Services (CMS), 42 C.F.R. §422.503 and 42 C.F.R. §423.504, providers and their employees are required to annually complete the FWA training offered on the HPSJ/MVHP website or complete another, acceptable FWA training and provide proof of training. Proof can be a certificate of completion, training program outline, or web link to the training. After choosing one of the training options, providers must attest for themselves and their employees who completed the training by completing the attestation below.

An Authorized Person can complete the training attestation on behalf of your practice for each provider and staff.

Name of Contracted Entity/Practice Name:	Practice Address:
Practice TIN#:	Practice NPI#:

☐ I am the only provider at my practice

Training- Option 1: ☐ Provided by HPSJ/MVHP Training Date:_____

Training- Option 2: ☐ Provided by_____Training Date:_____

I attest to having received the annually required Network Provider Anti-Fraud, Waste & Abuse Training and resources for the Medi-Cal/Medicaid program. ***Please sign and date below.***

Print Provider/Authorized Name Here	**Title**	**Signature**
Date	**Email**	**Phone Number**

Please send this completed form to HPSJ/MVHP at **providernetworks.verification@hpsj.com** and fax **(209) 933-3700**
This training is required for all providers and their staff. Please list all providers and staff who also completed the training.

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Additional Providers and Employee Names Below:

Provider and Employee Name (Last Name, First Name):	Provider Individual NPI#: