DOCTORS
HEALTHCARE PLANS.INC

Provider Compliance Requirements Attestation Form

DATE: _____/_____/_____

Initial Training: _____ **Annual Training: _____**

Provider Name: _____

I hereby acknowledge that I have received, read, and completed compliance training requirements for participating, contracted providers and business partners as follows:

- ***General Compliance and Fraud, Waste and Abuse Training accessible through:***
  - **CMS, interactive Web – Based Training (WBT) modules on the CMS Medicare Learning Network (MLN)** at https://learner.mlnlms.com/Default.aspx
  - **A PDF document combining the trainings available on the DHCP website at *www.doctorshcp.com***
- ***Doctors HealthCare Plans, Inc. Code of Conduct accessible at www.doctorshcp.com***

_____ _____

Printed Name **Tax ID Number**

_____ **Date: _____/_____/_____**

Signature