



NEW WEST MEDICARE
MEDICARE SIMPLIFIED

ATTESTATION OF TRAINING COMPLETION
Medicare Advantage – Prescription Drug
Fraud, Waste, and Abuse Training 2010

I attest that I have completed Fraud, Waste, and Abuse training as mandated by the Centers for Medicare and Medicaid Services (CMS):

CHECK ONE:

I reviewed the New West Health Services presentation on _____
 (Month/Day/Year)

I reviewed training and education offered by another Medicare Advantage and Part D sponsor or another source on _____
 (Month/Day/Year)

Please complete the following information if you received training from another source:

_____ Organization Name

_____ Street Address

_____ City, State, Zip Code

Please complete the following applicable information which is required for tracking purposes:

First Name	
Last Name	
Employer/Business	
Street Address	
City	
State, Zip Code	
Phone Number	
NPI Number	
License Number	
TIN	

 Signature

 Date

Please sign and return by fax (406) 457-2299 or
 Mail to: New West Health Services, 130 Neill Ave, Helena, MT 59601.