BlueCross BlueShield of Illinois

Attestation of Training Completion Form

The undersigned Organization/Person ("Organization/Person") certifies and attests that as a first-tier entity, downstream entity or related entity (as such terms are defined by Centers for Medicare and Medicaid Services , it has obtained and/or conducted required training for it and for all of its personnel and employees, as applicable, (including the Chief Executive, senior administrators or managers, and governing body members), as required for the provision of services under the contracts for the **Blue Cross Community Health Plans**℠ and/or **Blue Cross Community MMAI (Medicare-Medicaid Plan)**℠ plans.

Please mark the method(s) of training and education that you or your organization chose to comply with this requirement, as well as the date this training was completed:

	Training Type	Date Completed	Training completed with: (Health Plan Name)
☐	Model of Care/Medical Home		
☐	Fraud Waste Abuse		
☐	Abuse, Neglect, Exploitation/ Critical Incidents		
☐	Cultural Competency		
☐	Americans with Disabilities Act/Independent Living		
☐	General Compliance		

In addition, the Organization/Person certifies and attests that it has required its downstream entities to certify and attest that they have obtained and conducted, as applicable, the required training for all personnel and employees, as applicable. Upon request by the State of Illinois or CMS, the Organization/Person will furnish training logs, as well as certifications or attestations it obtains from its downstream entities to validate that the required training was completed.

Name of Organization/Person

NPI or Tax ID

Name of Organization Representative

Representative Title

Signature

Street Address

Date Signed

City, State, ZIP Code

If more than one individual in your organization completed the training listed above, please complete page 2 of this form.

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Please list individuals in your organization that have completed the training noted on page 1 of this form:

Affiliated Provider TIN	Name – Please Print (Last, First)	Position

Please return this form to **govproviders@bcbsil.com**.