Fraud, Waste, and Abuse Training: Anti-Kickback Statute

Date (mm/dd/yyyy): _____

Practitioner Name: _____

Group Name/TIN: _____

Practitioner Address: _____

City, State, Zip: _____

Practitioner Specialty: _____

The above organization/person certifies and attests that as a first-tier entity, downstream entity or related entity, has obtained and/or received Fraud, Waste and Abuse awareness training, specifically the Anti-Kickback Statute, for it and its personnel and employees.

By submitting this form, the undersigned agrees to the following:
That I completed training and education provided by Wellcare through the method checked below:

- ☐ Webinar
- ☐ Web-based
- ☐ Visit with Provider Relations Representative

Please print your name and sign at the bottom portion of this letter. To return, please scan and email to NTC-Compliance@NebraskaTotalCare.com.

Printed Name: _____ Signature: _____