MAGELLAN HEALTH SERVICES
Getting Better All the Time

Centers for Medicare & Medicaid Services (CMS) Fraud, Waste and Abuse

Compliance Certification

This Compliance Certification applies to all individuals and entities that contract with Magellan Behavioral Health ("Magellan") and provide services to members under the Medicare Advantage (Part C) plans.

Check only one box below:

If you completed the required CMS compliance training *through Magellan*:

☐ I hereby certify, as the practitioner or the authorized representative having responsibility directly or indirectly for all employees, contracted personnel, providers/practitioners, and vendors providing health care or administrative services under Medicare Advantage, that the fraud, waste and abuse (FWA) compliance training provided by Magellan has been completed.

If you completed comparable CMS compliance training through *another organization*:

☐ I hereby certify, as the practitioner or the authorized representative having responsibility directly or indirectly for all employees, contracted personnel, providers/practitioners, and vendors providing health care or administrative services under Medicare Advantage (Part C), that in lieu of completing the fraud, waste and abuse (FWA) training provided by Magellan, another FWA compliance training that meets or exceeds the recommendations as outlined by CMS has been completed.

Name of organization that provided training: _____

Date training was completed: _____
(Required if not completing the CMS compliance training provided by Magellan)

If you completed the required CMS training through *CMS* *(individual attestation required)*:

☐ I hereby certify, as the practitioner providing health care or administrative services under Medicare Advantage, that the fraud, waste and abuse (FWA) compliance training provided by CMS as part of my enrollment process has been completed. (If you are part of a group, each group member must attest separately. Please make copies of this form for each individual for which this is applicable.)

Please complete:

Name of practitioner, facility or group: _____

Authorized representative's name: _____

Authorized representative's signature: _____

Date: _____

Authorized representative's telephone number: _____

Authorized representative's email address: _____

Contract entity Taxpayer Identification Number (TIN): _____MIS#: _____

This certification serves as verification for all applicable affiliates under the TIN identified.

Return this certification form to:
Magellan Health Services
Attn: Org Network Services
14100 Magellan Plaza
Maryland Heights, MO 63043
Or fax to: 1-888-656-3804