

IPA Name: \_\_\_\_\_

c/o MedLogix MSO, LLC  
16027 Brookhurst St. Suite 10-109  
Fountain Valley, CA 92708  
Phone: 657-217-4500 \* Fax: 657-217-4501

**COMPLIANCE, FWA, HIPPA, SNP MODEL OF CARE TRAINING ATTESTATIONFORM**

The below provider/entity acknowledges that the Select Healthcare Systems Inc. Compliance Training and Education, which includes training on Compliance, FWA, HIPAA and SNP Model of Care (MOC) training, has been accessed via **https://www.medlogixmso.com/?page\_id=80**. It is understood that it is the providers' obligation to read and become familiarize with these trainings and follow regulatory requirements.

By signing the below, the signor is certifying that the contents of the referenced materials below have been reviewed and agree to abide by all regulatory requirements and processes outlined in these documents.

Initial Training                       Annual Training

- 1.  Combating Medicare Parts C & D FWA
- 2.  Detection of Medicare Parts C & D FWA
- 3.  HIPAA Basics – Privacy Security & Breach Notice
- 4.  Cultural Competence & Language Assistance
- 5.  SNP Model of Care (MOC)

Please Print:

Organization/Practice Name: \_\_\_\_\_

Group NPI: \_\_\_\_\_

Physician Name: \_\_\_\_\_ NPI: \_\_\_\_\_

Physician Name: \_\_\_\_\_ NPI: \_\_\_\_\_

Physician Name: \_\_\_\_\_ NPI: \_\_\_\_\_

Physician Name: \_\_\_\_\_ NPI: \_\_\_\_\_

If necessary, please attach additional sheets, including organization/practice name, group NPI, physician name and NPI)

By signing this form, I attest that the fore mentioned trainings have been received, reviewed. I acknowledge all information and obligation of compliance are understood.

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_

Please return completed, signed attestation by fax to the attention of Provider Network at (657) 217-4501.