



**Attestation**  
**Fraud, Waste and Abuse Training**  
**Completed Through Other Carrier**

In order to comply with the Centers for Medicare and Medicaid Services' (CMS) requirement, I attest that I have completed Fraud, Waste and Abuse training in 2009 through \_\_\_\_\_ on \_\_\_\_\_  
*(Health Insurance Carrier Name)*  
*(Month/Date/Year)*

\_\_\_\_\_  
Office Name

\_\_\_\_\_  
Office Address

\_\_\_\_\_  
Office Phone

\_\_\_\_\_  
Office Fax

\_\_\_\_\_  
Your Title

\_\_\_\_\_  
Your Name *(Please Print)*

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Today's Date

*Please print and sign this attestation form and fax (330-996-8490) or mail: Po Box 3620 Akron OH 44309 the form to SummaCare -Provider Support Services.*