sunshine health

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 Sunshine Health through the method checked below:**
  - ☐ **Webinar**
  - ☐ **Web-based**
  - ☐ **Visit with Provider Partnership Manager**

Please print your name and sign at the bottom portion of this letter and return in the enclosed business reply envelope (if received by mail), scan and email to SSHPAnti-Kickback@centene.com, or submit to your Sunshine Health Provider Partnership Manager.

_____ _____

Printed Name **Signature**