



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