Heritage Provider Network & Affiliated Medical Groups

FDR Compliance Attestation

(First Tier, Downstream and Related Entities (FDR), please complete, sign, and fax this Attestation)

FDR Name and Address: ____
____
____

In recognition of FDR's status and role as a covered entity, contracted with Heritage Provider Network and its Affiliated Medical Groups ("HPN"), FDR attests to the following statements:

FDR has in place an effective compliance program, meeting CMS standards to detect, prevent, and report instances of Fraud, Waste, and Abuse ("FWA"), other non-compliance, or Health Insurance Portability and Accountability Act ("HIPAA") Privacy or Security issues;

FDR screens all employees, officers, and vendors against the OIG/GSA Excluded Persons Lists prior to hire/contract, and monthly thereafter;

FDR and all staff engaged with treatment, administration, or support of CMS members, have completed all required initial new hire and annual trainings as follows:

a. FDR and staff have completed the required 2015 CMS annual FWA training* on (or before): __________/2015; and
b. FDR and staff have completed the 2015 CMS annual Medicare Compliance training*on (or before): __________/2015 (*as required by 42 CFR 422.503 and 42 CFR 423.504).
c. FDR and staff have completed HIPAA training on (or before): __________/2015.
d. FDR and staff have completed the Model of Care (MOC) training on (or before): __________/2015 (only applicable to persons directly involved with patient care).

FDR agrees to notify HPN's Compliance Officer within 3 business days upon discovery of any FWA, non-compliance, or suspected violation of the HIPAA, HITECH Act, Medical Advantage, CMS regulations, or any other statute, regulation, and/or policy and procedure;

FDR understands that any privacy incident involving any Medi-Cal or Medicaid patient requires notice to HPN and the California Department of Health Services within 1 business day from discovery.

FDR understands that, upon HPN's request, it agrees to provide HPN's Compliance Officer with documentation to substantiate its screening, training, and/or compliance and privacy program activities.

I have completed the above and certify it as true and accurate, as of today, ______/_______/_______.

Signature: ____

[ ] Attached, please find a roster of our credentialed staff members or contracted individual providers, for whom we are attesting on behalf of (including names, license numbers, and NPI numbers).

Please fax your completed form to: