



**Medicare Part D Community Provider Specialized Training
2009 Attestation**

I hereby certify as a **prescribing provider**, that the Centers for Medicare & Medicaid (CMS) Part D program participation requirements have been satisfied as outlined below.

- Medicare Part D Introduction
- Part D Program Standards
- Part D Guidance
- Government Initiatives
- Part D FWA Risks
- Part D FWA Prevention
- Coverage Determinations, Exceptions & Appeals
- Reporting Suspicious Activity

PRINT Name
Prescribing Provider or Authorized Individual
(legible for tracking purposes)

Date

Prescribing Provider or Authorized Individual Signature

Contract Entity Tax Identification Number

If 2009 training has been completed through another Medicare Part D plan, please complete the information below:

Medicare Part D Plan Name

Date Completed

PLEASE SIGN AND RETURN TO THE FAX NUMBER BELOW:

Lovelace Health Plan Compliance Department
Attention: Medicare Part D Compliance Analyst
Fax :(505) 727-5510
Phone: (505) 727-5524
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