2023 Fraud, Waste Abuse (FWA) and General Compliance Training Log

Pharmacy Name _____

List all training materials provided and attach a copy or copies to this log:

_____

_____

_____

Employee Name	Title	Date Provided

NOTE: CMS requires records demonstrating compliance with these requirements be maintained for ten (10) years. This includes all individuals trained be listed along with the date the FWA and general compliance training information is provided/completed, and date of Department of Health and Human Services (HHS)- Office of Inspector General(OIG)/General Services Administration's (GSA) monitoring review.

PharmPix Pharmacy Network Provider Fraud, Waste and Abuse (FWA) and General Compliance Training Attestation

PharmPix Contracted Network Provider Pharmacies are required to sign this attestation to satisfy mandatory compliance requirements regarding federal health care government sponsored programs regulatory requirements as well as related guidance issued by the Centers for Medicare & Medicaid Services (CMS). CMS has set forth expressed guidance within the Federal Register and at Title 42 of the Code of Federal Regulations (CFR), Parts 422, 423, 425 and 438, among others, and other agency guidance requiring Plan sponsors, or their delegates, first tier, related, and down-stream (FDR) entities to demonstrate compliance with the following:

1. Contracted Network Provider Pharmacy hereby verifies and certifies that it has reviewed and conducted satisfactory annual Fraud, Waste and Abuse (FWA) and general compliance training programs or has utilized the training program provided by CMS with pharmacy staff. In addition, Contracted Network Provider Pharmacy hereby verifies and certifies that neither it, nor its employees have been excluded from participation in federal health care programs by checking its status in Federal programs exclusion lists maintained by the General Services Administration (GSA) and the Department of Health and Human Services Office of Inspector General (HHS-OIG). Pharmacy has reviewed the Health & Human Services (HHS) Office of Inspector General (OIG) and General Services Administration's (GSA) lists prior to hire/contracting and monthly thereafter for its current employees/contractors, health professionals, or vendors that work on federal government sponsored programs, including among others, MA, Part D or Medicaid programs to ensure that none are excluded from participating in these programs. This information is available at the following sites:

Federal programs exclusion lists	Address
Office of Inspector General's (OIG) List of Excluded Individuals/Entities (LEIE)	https://oig.hhs.gov/
General Services Administration (GSA) Excluded Parties List System (EPLS)	https://fsd.gov/fsd-gov/home.do
General Services Administration (GSA) System for Award Management (SAM)	https://fsd.gov/fsd-gov/home.do
Healthcare Integrity and Protection Data Bank	https://www.npdb-hipdb.com

2. Contracted Network Provider Pharmacy hereby verifies and certifies that attendance logs, materials, training documents, and other evidence in support of compliance with item "1." above is and shall continue to be made available by Network Contracting Pharmacy for inspection and review by PharmPix during on-site audits or other review processes. This inspection may also be conducted by the Payer(s) and other federal regulatory agencies as outlined in regulations including, but not limited to, 42 CFR 422.504(e) and 422.503(d)(2)).

NOTE: CMS requires records demonstrating compliance with these requirements be maintained for ten (10) years. This includes all individuals trained be listed along with the date the FWA and general compliance training information is provided/completed, and date of Department of Health and Human Services (HHS)-Office of Inspector General(OIG)/General Services Administration's (GSA) monitoring review.

Pharmacy Name _____

NCPDP Number _____ **NPI Number** _____

Telephone Number _____ **Date** _____

Name of Authorized Individual Completing Attestation _____

Title of Authorized Individual Completing Attestation _____

Signature _____

Exhibit C-1

APPLICATION SECTION

1. If you have three or more pharmacies being covered by this contract, do you have a NCPDP chain code? If yes, please list chain code(s):	Yes	No
2. Do you maintain patient profiles? If yes, are they electronic?	Yes	No
3. Do you review prescriptions dispensed for drug interactions?	Yes	No
4 Is this pharmacy equipped to submit claims electronically in the most current NCPDP format? If no, please explain:	Yes	No
5. Are you affiliated with a buying group or Co-op? If so, please list name:	Yes	No
6. Is this pharmacy affiliated with any other pharmacy or entity, which presently maintains a pharmacy agreement with PHARMPIX? If yes, please list.	Yes	No
7. Do you provide any special services or have distribution rights to any specialty medications? *If yes, please attach detail.*	Yes	No
8. Has your pharmacy or another pharmacy you have owned ever received less than satisfactory rating by the State Board of Pharmacy, ever had its license or registration suspended/revoked or any other action taken against it? *If yes, attach explanation.*	Yes	No
9. Have any of your pharmacists ever been disciplined by the State Board, the State or Federal DEA or the State Medicaid Department? *If yes, attach explanation.*	Yes	No
10. Has the pharmacy, under current ownership, or any of its currently employed pharmacists ever been the subject of a civil lawsuit or criminal prosecution for fraud, deceit, deception or a similar offense involving moral turpitude? *If yes, attach explanation.*	Yes	No
11. Has the pharmacy, under current ownership, or any of its principals ever filed for bankruptcy, reorganization, or made a general assignment in favor of creditors? *If yes, attach explanation.*	Yes	No
12. Has the Pharmacy or any of its principals or pharmacists, ever been suspended or excluded by the Office of Inspector General (OIG) from participating in any federal or state health care program (e.g., Medicare, Medicaid, CHAMPUS) or by the General Services Administration (GSA) from participating in any government contract/services. *If yes, attach explanation.*	Yes	No
13. Has the Pharmacy ever changed names? If yes, when? *If yes, attach a list of the previous name(s):*	Yes	No
14. Has the Pharmacy ever undergone a change in ownership? If yes, when? *Please attach a list of the previous owner's name(s).*	Yes	No
15. Is the Pharmacy a Medicare Part B Provider? If yes please provide the Pharmacy's Part B Provider Number:	Yes	No

Pharmacy Name:	**City:**
NPI:	**NCPD:**
Name of Authorized Representative:	
Signature:	**Date:**