NORTH SOUND BEHAVIORAL HEALTH
ADMINISTRATIVE SERVICES ORGANIZATION

301 Valley Mall Way, Suite 110, Mt. Vernon, WA 98273
360.416.7013 | 800.864.3555 | F: 360.416.7017
www.nsbhaso.org

# COMPLIANCE TRAINING ATTESTATION STATEMENT

I, the undersigned, attest that I am an authorized representative with signature authority for the individual or entity listed below and that all employees and downstream entities (sub-contractors) that provide health care or administrative services for North Sound BH-ASO members at or on behalf of my organization have completed, or will complete the following Centers for Medicare & Medicaid Services (CMS) trainings: *Combatting Parts C and D Fraud, Waste, and Abuse Training*.

**Organization Information**

| | | | |
|---|---|---|---|
| Entity Name: | | | |
| Address: | | | |
| City: | | | |
| State: | | Zip Code: | |
| Phone Number: | | | |
| NPI or TIN Number: | | Medicare / Medicaid #: | |

**Attestation Signature**

***Anyone who knowingly and willfully makes or causes to be made a false statement or representation of this statement, may be prosecuted under applicable federal or state laws. In addition, knowingly and willfully failing to fully and accurately disclose the information requested may result in denial of a request to participate or where the entity already participates, a termination of its agreement or contract with North Sound BH-ASO.***

***By signature I certify that the information provided here, is true and correct, and I understand that CMS, HCA, or North Sound BH-ASO may request additional information to substantiate the statements made in this attestation.***

| | |
|---|---|
| Name of Individual Completing This Form: | |
| Title of Individual Completing This Form: | |
| Phone Number of Individual Completing This Form: | Email of Individual Completing This Form: |
| Signature of Individual Completing This Form (electronic signatures are same as physical): | Date: |

**Submit Completed Forms to Compliance_Officer@nsbhaso.org**