

## Training Verification Form

**Instructions:** Complete, sign, date and return this form with any required attachments that demonstrate training completion to the contact listed at the bottom of this form. Incomplete forms or forms submitted without required attachments will not be accepted.

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Practice name: \_\_\_\_\_

Provider(s): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Training program name: \_\_\_\_\_

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Attestation:

I hereby attest that, on \_\_\_\_\_ (date), I completed the training program and all related actions required by the training.

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name: \_\_\_\_\_ Title: \_\_\_\_\_

**Please return this completed form to:**

[Provider Relations Representative]  
Anthem Blue Cross and Blue Shield Medicaid  
13550 Triton Park Blvd., Third Floor  
Louisville, KY 40223  
Fax: **1-800-964-3627**

<https://mediproviders.anthem.com/ky>

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