# 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**





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