Amerigroup RealSolutions in healthcare

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.

Practice name: _____

Provider name(s):	NPI:

City: _____ State: _____ ZIP code: _____

Phone: _____ Fax: _____

Email: _____

Training program name: _____

Attestation:

I hereby attest that, on _____ (insert date), the practice/providers listed above have completed the above named training program and all related actions required by the training.

Signature: _____ Date: _____

Printed name: _____ Title: _____

Please return this completed form to:

Amerigroup Community Care
Attention: Network Management
303 Perimeter Center North, Suite 500
Atlanta, GA 30346
Fax: 1-866-574-6720