

**COMPLIANCE ATTESTATION FORM**

**Compliance Training** *Please review the provided Compliance Training*

By signing below, I am certifying I have reviewed the contents of the referenced materials and agree to abide by all regulatory laws and procedures as outlined in these documents.

* agilon health Code of Conduct
* CMS Medicare Parts C and D Compliance Training
* CMS Medicare Parts C and D FWA Training
* agilon health Compliance Training

o HIPAA Privacy & Security Training

o Supplemental

* ICE Cultural Competency Training

I attest that I have received and reviewed with my staff and providers and will report any/all suspected

violations to the agilon health Compliance Officer.

**Records Retention**

By signing below, I attest that our office maintains all records related to administration or delivery of Part C and/or Part D benefits accordance with applicable federal and state laws.

If there is a “No” response to any of the questions above, please use the field below to provide a corrective action plan (CAP) to address each instance of non-compliance. Please include contact information, and projected completion date(s).

**OIG/GSA Exclusions Monitoring**

*Answer the questions below indicating your compliance with exclusion screening of providers and staff. If you are in need of more information on this requirement, please reach out to complianceah@agilonhealth.com*

1. Provider(s) and employees are **not** currently excluded from participation in any federal or state healthcare programs.

Not Currently Excluded  Currently Excluded

1. All providers and Employees are screened against the Office of Inspector General (OIG) List of Excluded Individuals and Entities (LEIE) and General Services Administration (GSA) System for Award Management (SAM), and applicable state Medicaid exclusion list prior to initial hire or contracting and monthly thereafter and maintains evidence of all screening activities and results.

Yes No

1. Providers or employees are immediately removed if found on the OIG or GSA exclusion lists, from any work related (directly or indirectly) to federal or state health care programs.

Yes No

If there is a “**No**” response to any of the questions above, please use the field below to provide a corrective action plan (CAP) to address each instance of non-compliance. Please include contact information, and projected completion date(s).

**Sub-Delegation**

Does your office sub-delegate to a downstream entity? ☐Yes ☐No

If yes, provide the entity name, functions they perform, and monitoring of entity:

|  |  |
| --- | --- |
| Staff Member Name: |  |
| Signature: |  |
| Date: |  |
| Clinic Name: |  |
| Provider Name(s): |  |
| TIN: |  |

**\*\*Please check box below with the groups you are contracted with\*\***

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Description automatically generated

**Compliance Hotline:** (833) 668-8638 or **Email:** [complianceAH@agilonhealth.com](mailto:complianceAH@agilonhealth.com)