Training Verification Form

Instructions: Complete, sign, date and return 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.

Practice name: ____

Provider(s): ____

City: ____ State: _______ ZIP: __________________

Phone: ___________________________________ Fax: ____

Email: ___________________________________

Training program name: ____

Attestation:

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

Signature: ____ Date: _____________________

Printed name: ____ Title: _____________________

Please return this form to:

Provider Relations Department
Amerigroup Washington, Inc.
705 Fifth Avenue South, Suite 300
Seattle, WA 98104
Fax: 855-270-9583

PF-ALL-0101-12