BadgerCare Plus

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 ______________ (insert date), I completed the training program and all related actions required by the training.

Signature: ______________ Date: ______________

Printed name: ______________ Title: ______________

Please return this completed form to:

Anthem Blue Cross Blus Shield
Medicaid Business
Guy Stuller
N17 W24340 Riverwood Drive
Waukesha, WI 53188
FAX: 262-523-4980

www.anthem.com/wimedicaiddoc

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