2020 Notice of Additional Compliance Requirements for Pharmacies Supporting Florida, Illinois and/or Kentucky

Humana requires all entities, including pharmacies, that contract with Humana or a Humana subsidiary and perform one or more functions in support of Humana’s offerings for Medicaid and/or dual Medicare-Medicaid beneficiaries to adhere to the compliance program requirements outlined below and provide an attestation of such adherence.

Training on the following topics is required for pharmacies located in Florida, Illinois, Kentucky and/or surrounding areas that serve dual Medicare-Medicaid or Medicaid-only beneficiaries in plans administered by Humana:

- Humana Medicaid Pharmacy Orientation and Provider Training
- Health, Safety and Welfare Education Training
- Cultural Competency Training

Please complete the attestation on the next page and fax it to 1-877-820-5740.

Please direct questions about this notice to:

HumanaPharmacyCompliance@humana.com or 1-888-204-8349
2020 Medicaid-specific Training Attestation Form for Pharmacy Providers
Supporting Florida, Illinois and/or Kentucky

Please confirm only one option is selected for each section.
Fax to 1-877-820-5740.

**Medicaid Pharmacy Orientation and Provider Training** (accessible at [Humana.com/provider/pharmacy-resources/manuals-forms](Humana.com/provider/pharmacy-resources/manuals-forms))
As a duly authorized representative of the Organization, I hereby acknowledge and agree that the Organization:
• Has been provided, read and understands Medicaid Pharmacy Orientation and Provider Training; and
• Adopts either Medicaid Pharmacy Orientation and Provider Training or another orientation that is materially similar to Humana Orientation Training.
□ Accept – My Organization agrees to train its applicable employees and downstream entities this calendar year by using Medicaid Pharmacy Orientation and Provider Training.
□ Accept – My Organization agrees to train its applicable employees and downstream entities this calendar year by using another orientation that is materially similar to Medicaid Pharmacy Orientation and Provider Training.

**Health, Safety and Welfare Education Training** (accessible at [Humana.com/provider/pharmacy-resources/manuals-forms](Humana.com/provider/pharmacy-resources/manuals-forms))
As a duly authorized representative of the Organization, I hereby acknowledge and agree that the Organization:
• Has been provided, read and understands Humana Health, Safety and Welfare Education Training; and
• Adopts either Humana Health, Safety and Welfare Education Training or other training that is materially similar.
□ Accept – My Organization agrees to train its applicable employees and downstream entities this calendar year by using Humana Health, Safety and Welfare Education Training.
□ Accept – My Organization agrees to train its applicable employees and downstream entities this calendar year by using another training that is materially similar to Humana Health, Safety and Welfare Education Training.

**Cultural Competency Training** (accessible at [Humana.com/provider/pharmacy-resources/manuals-forms](Humana.com/provider/pharmacy-resources/manuals-forms))
As a duly authorized representative of the Organization, I hereby acknowledge and agree that the Organization:
• Has been provided, read and understands Humana Cultural Competency Training; and
• Adopts either Humana Cultural Competency Training or another training that is materially similar.
□ Accept – My Organization agrees to train its applicable employees and downstream entities this calendar year by using Humana Cultural Competency Training.
□ Accept – My Organization agrees to train its applicable employees and downstream entities this calendar year by using another training that is materially similar to Humana Cultural Competency Training.

Reviewed and Agreed:

___________________________   ___________________________  ___________________
Printed name    Signature    Date

___________________________   ___________________________
Title    Organization name

___________________________   ___________________________
Phone number    Fax number

National Provider Identifier(s): __________________________________________________________________________________________

___________________________   ___________________________   ____________________________
Organization street address    City    State    ZIP code