

**Attestation of Completed Training**

Training: **Medicaid Adverse Benefit Determination Process**I hereby attest that I completed the training listed above. I listened, read, and understood the training. I understand that as an employee of a Medicaid treatment provider it is my responsibility to abide by Medicaid rules and requirements. If I have questions about the training, materials presented, or requirements, I understand it is my responsibility to seek clarification.

Click or tap here to enter text.

Organization Name

Click or tap here to enter text.

Print Name

Click or tap here to enter text.

Title/Role

[ ]  I completed the training

Attestation

 Click or tap to enter a date.

Completion Date