Humana

2024 Notice of Additional Compliance Requirements for Pharmacies Supporting Plans in Florida, Illinois, Indiana, Oklahoma and/or South Carolina*

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 and Medicaid beneficiaries to:

- Adhere to Compliance Program Requirements, including those outlined below; and
- Provide an attestation form to certify adherence to these additional requirements.

Training on the following topics is required for pharmacies in Florida, Illinois, Indiana, Oklahoma, South Carolina and/or surrounding areas and serve dual Medicare and Medicaid or Medicaid-only beneficiaries in plans administered by Humana in any of the above states:

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

Please complete the attestation form on the next page and fax it to **877-820-5740**. Please email questions about this notice to HumanaPharmacyCompliance@humana.com or call **888-204-8349**.

* Supporting Humana in one of the above states does not automatically mean the work performed is for Humana offerings for Medicaid and/or dual Medicare and Medicaid beneficiaries in those states.

2024 Medicaid-Specific Training Attestation Form for Pharmacy Providers Supporting Plans with a Medicaid Component in Florida, Illinois, Indiana, Oklahoma and/or South Carolina

Please confirm only one option is selected for each section.

Fax to 877-820-5740.

Medicaid Pharmacy Orientation and Provider Training (accessible at **Humana.com/Provider/Pharmacy-Resources/Manuals-Forms**)

As a duly authorized representative of the Organization, I hereby acknowledge and agree that the Organization:

- Has 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.

☐ 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)**

As a duly authorized representative of the Organization, I hereby acknowledge and agree that the Organization:

- Has 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**)

As a duly authorized representative of the Organization, I hereby acknowledge and agree that the Organization:

- Has 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 by Contracted Entity: _____:

_____	_____	_____
Printed name	Signature	Date
_____	_____	☐ FL ☐ IL ☐ IN ☐ OK ☐ SC
Title	Organization name (if different than Contracted Entity)	Indicate state(s) where pharmacy supports a Medicaid contract
_____	_____	
Phone number	Fax number	

National Provider Identifier(s): _____

_____	_____	_____	_____
Organization street address	City	State	ZIP code