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ANNUAL COMPLIANCE ATTESTATION
FIRST TIER, DOWNSTREAM AND RELATED ENTITIES (FDR)

I have the authority to attest on behalf of my organization, _____, and I attest the following:

Required Exclusion Checks

1. For all employees, temporary employees, volunteers, consultants, governing body members and for applicable downstream and/or related entity relationships, we ensure they are not excluded from participation in federal health care programs by checking the OIG's List of Excluded Individuals and Entities (LEIE), GSA's System for Award Management (SAM), State Medicaid Excluded Provider lists, Medicare Opt Out status, DEA Registry, if applicable, prior to hire or contract and monthly thereafter. If any of the previously referenced individuals are identified on any of these exclusion lists, they shall be immediately removed from any work directly or indirectly related to federal or state health care programs.

   ☐ I attest to the above statements.

2. In addition to completing the actions identified in Section 1, for those functions related to services covered by State Public Programs, we also confirm the identity, and determine the exclusion status of all Providers, Individuals with an Ownership or Control Interest, our Agents, and any Managing Employees, upon contract execution or renewal, and credentialing, through routine checks of state and federal databases. The databases checked include the Social Security Administration's Death Master File and the National Plan and Provider Enumeration System (NPPES).

   ☐ I attest to the above statements.

   OR

   ☐ This is not applicable to my organization.

3. For services covered by State Public Programs, we will provide UCare the name, address, date of birth, social security number (in the case of an individual), and tax identification number (in the case of a corporation) of each Person with an Ownership or Control Interest in the disclosing entity or in any Subcontractor in which the disclosing entity has direct or indirect ownership of five percent (5%) or more.

   ☐ I attest to the above statements.

   OR

   ☐ This is not applicable to my organization.

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Monitoring Downstream Entities

4. We have a system in place to monitor applicable downstream entities' compliance with Medicare and State Public Program requirements where applicable to my organization.

   ☐ I attest to the above statement.

   OR

   ☐ This is not applicable to my organization.

Code of Conduct

5. My organization has established and publicized a Code of Conduct that is comparable to UCare's Code of Conduct since it meets the requirements of Medicare Managed Care Manuals Chapters 9 and 21.

   ☐ I attest to the above statement.

Reporting Suspected Compliance and Fraud, Waste and Abuse Concerns

6. Through our Compliance and FWA programs, we instruct our employees and any applicable downstream and related entities to report to UCare any suspected Medicare and/or State Public Program violations and fraud, waste and abuse concerns that affect UCare payments or members.

   ☐ I attest to the above statement.

   OR

   ☐ I attest that through our Compliance and FWA programs we instruct our employees and any applicable downstream and related entities to report to our Compliance Officer, suspected Medicare and/or State Public Program violations and any fraud, waste and abuse concerns that affect UCare payments or members, who will then report those concerns and violations to UCare.

Offshore Subcontracting

7. Our organization, including subcontractors, does not transmit, store, use, or disclose protected health information (PHI) outside of the United States, including its five territories American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and U.S. Virgin Islands, nor do we perform any services involving the transmission, storage, use, or disclosure of PHI outside of the United States. Our organization will obtain UCare's written approval prior to engaging in any of the offshore activities described in this section.

   ☐ I attest to the above statement.

OR

☐ I attest that our organization, including subcontractors, does transmit, store, use or disclose PHI outside of the United States, including its five territories, and/or we do perform services involving the transmission, storage, use, or disclosure of PHI outside of the United States. We have previously notified UCare of this in writing, completed and submitted UCare's Offshore Attestation, received UCare's written approval, and we complete an annual audit of all offshore services and subcontractors.

OR

☐ I attest that our organization, including subcontractors, does transmit, store, use or disclose PHI outside of the United States, including its five territories, and/or we do perform services involving the transmission, storage, use, or disclosure of PHI outside the United States. Our organization will complete UCare's Offshore Attestation and seek UCare's written approval for such offshoring activities.

If you are unable to attest the above statement, please contact UCare's Provider Network Management Department at providerapp@ucare.org

Business Continuity Plan

8. Maintain and implement a Business Continuity Plan (BCP) containing policies and procedures to ensure the restoration of business operations following disruptions to business operations which would include natural or man-made disasters, system failures, emergencies, and other similar circumstances and the threat of such occurrences. To meet the requirement, the business continuity plan must, at a minimum, include the following:

   On at least an annual basis, test and update the business operations continuity plan to ensure the following:

   (A) That it can be implemented in emergency situations.

   (B) That employees understand how it is to be executed.

☐ I attest to the above statement.

There is a documented Disaster Recovery Plan in place, that is tested annually, for all critical and essential systems that may not be interrupted or delayed for more than (14) days.

☐ I attest to the above statement.

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I attest the information provided is accurate to the best of my knowledge.

Print Name	**Signature**
Title	**Date**
Organization	
Email Address	**Organization Website URL**

Please return the completed form to UCare by email to providerapp@ucare.org, or mail a hardcopy to UCare, ATTN: Provider Network Management, PO Box 52, Minneapolis, MN 55440

If you are unable to attest to any portion of this document or wish to provide additional information to one or more of the above statements, please provide your explanation in the space below.

Explanation: