



2025 Notice of Additional Compliance Requirements for Pharmacies Supporting a Plan in Indiana*

Humana requires the following of 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 beneficiaries:

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

Annual training on the following topics is required for pharmacies in Indiana and/or surrounding areas when they are contracted to serve Medicaid-only beneficiaries in plans administered by Humana in Indiana:

- 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**.

* Supporting Humana in Indiana does not automatically mean the work performed is for Humana offerings for Indiana Medicaid.

**2025 Medicaid-Specific Training Attestation Form for Pharmacy Providers
Supporting a Plan with a Medicaid Component in Indiana**

Please complete this form and fax it to 877-820-5740.

Medicaid Pharmacy Orientation and Provider Training (The training is accessible at **Provider.Humana.com/pharmacy-resources/manuals-forms**. Please scroll down to “Manuals and forms” and select the “Medicaid training resources” tab.)

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

1. Has read and understands Humana Medicaid Pharmacy Orientation and Provider Training
2. Adopts Humana Medicaid Pharmacy Orientation and Provider Training

☐ Accept – My Organization agrees to train its applicable employees and downstream entities this calendar year by using Humana Medicaid Pharmacy Orientation and Provider Training.

Health, Safety and Welfare Education Training (The training is accessible at **Provider.Humana.com/pharmacy-resources/manuals-forms**. Please scroll down to “Manuals and forms” and select the “Medicaid training resources” tab.)

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

1. Has read and understands Humana Health, Safety and Welfare Education Training
2. Adopts Humana Health, Safety and Welfare Education Training

☐ Accept – My Organization agrees to train its applicable employees and downstream entities this calendar year by using Humana Health, Safety and Welfare Education Training.

Cultural Competency Training (The training is accessible at **Provider.Humana.com/pharmacy-resources/manuals-forms**. Please scroll down to “Manuals and forms” and select the “Medicaid training resources” tab.)

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

1. Has read and understands Humana Cultural Competency Training
2. Adopts Humana Cultural Competency Training

☐ Accept – My Organization agrees to train its applicable employees and downstream entities this calendar year by using Humana Cultural Competency Training.

Reviewed and agreed by Contracted Entity: _____

Printed name

Signature

Date

Title

Organization name (if different than
Contracted Entity)

Pharmacy supports a Humana Medicaid
contract in Indiana – check here ☐

Phone number

Fax number

National Provider Identifier(s): _____

Organization street address

City

State

ZIP code