January 2022 Provider Policy and Procedure Manual Annual Update
Provider Acknowledgment of Receipt (AOR)

Please complete the following information in order to receive future updates to the IEHP Provider Policy and Procedure Manual. By signing this AOR, I acknowledge that I have read and reviewed electronic copies of the following Manuals and Trainings:

1. **Provider Policy and Procedure Manuals** Medi-Cal and IEHP DualChoice - https://www.iehp.org/en/providers/provider-manuals
2. **Benefit Manuals are available to view on State and Federal links provided below:**
   - **Medi-Cal -** https://files.medi-cal.ca.gov/pubsdoco/Manuals_menu.aspx
   - **IEHP DualChoice -** https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html
3. **Summary of Effected Changes**
4. **IEHP Code of Business Conduct and Ethics**
5. **Guidelines for Care Management Training**
6. **Compliance Program Training** (Fraud, Waste and Abuse (FWA) HIPAA Privacy and Security)
7. **Cultural and Linguistic (C & L) Training**

I hereby attest that, to the extent required, all appropriate staff have received and/or been trained on the information contained in the documents listed above. I attest that the undersigned entity/organization has established and publicized compliance policies and procedures, standards of conduct, and compliance reference material that meet the requirements outlined in 42 CFR §422.503(b)(4)(vi), 42 CFR §423.504(b)(4)(vi), and 42 CFR §438.608(a)(1).

☐ PCP ☐ OB/GYN ☐ Specialist ☐ Vision ☐ Behavioral Health ☐ Direct Ancillary

Clinic/Entity Name **(IF APPLICABLE):** ______________________________

List of Providers within the Group **(PLEASE PRINT, does not apply to Direct Ancillary)**

1. ____________________ 5. ____________________

2. ____________________ 6. ____________________

3. ____________________ 7. ____________________

4. ____________________ 8. ____________________

Address: ______________________________

City: ____________________ State: ______ Zip: ______________

Phone: ____________________ Ext: ________ Fax: ______________

Signature **(REQUIRED)**: ____________________ Date:______________

Please return your signed AOR on or before <u>January 10, 2022</u>

Fax the completed form to **(909) 296-3550**, or e-mail the completed form to providerservices@iehp.org, or access the AOR form online located at https://iehp.org/en/providers/provider-manuals to signify your receipt and review of the enclosed Manual.