2023 IEHP DualChoice (HMO D-SNP) Model of Care (MOC) for Non-Contracted Providers Acknowledgment of Receipt (AOR)

By signing this AOR, I acknowledge that:

(1) I have read and reviewed electronic copies of the following Trainings:

☐ **D-SNP (HMO D-SNP)_Model of Care Training**
https://www.iehp.org/en/providers/provider-resources?target=Non-Contracted-Providers

I hereby attest that, to the extent required, all appropriate staff have received and reviewed the information contained in the documents listed above. I further attest that a plan/ timeline is in place to train staff within ninety (90) calendar days of completing this acknowledgement of receipt.

☐ PCP ☐ OB/GYN ☐ Specialist ☐ Vision

☐ Behavioral Health ☐ Direct Ancillary ☐ SNF ☐ CBAS

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 within 90 calendar days of receiving this notice.
Fax the completed form to **(909) 296-3550**, or e-mail the completed form to providerservices@iehp.org, or access the Model Of Care AOR form online located at https://www.iehp.org/en/providers/provider-resources?target=Non-Contracted-Providers to signify your receipt and review of the Model of Care training.