Care1st Health Plan

ANNUAL SNP MODEL OF CARE TRAINING ACKNOWLEDGEMENT 2017

Medical Group(s)/Provider:

_____

(Please write in your Medical Group or Individual Provider Name on the above line)

I acknowledge that I have completed the 2017 annual SNP Model of Care Training.

_____

Signature

_____

Print Name

_____

License(s)

_____

NPI/Tax Id

_____

County

_____

Date

You may fax or e-mail this signed form to Provider Network Operations:

Fax number: 323-889-5418

E-mail: SNPMOC@care1st.com