Preferred IPA of California
Be a Preferred Provider

Attestation for Model of Care Training – Provider

_____ I attest that I have received and read the Model of Care (MOC) training.
(Centers for Medicare and Medicaid (CMS) Regulation 42 CFR §422.102(f)(2)(ii).

_____ I attest that I am willing to participate in the MOC requirements for the members for whom I provide care. Such activities may include providing information to the Case Manager, updating the care plan when nescessary, discussing the care plan with the Health Plan Case Manager, and communicating with the Interdisiplanary Care Team as requested.

The MOC training covers all Medicare health plans contracted with Preferred IPA of California:
Alignment Health Plan, Blue Shield, Brand New Day, Blue Shield of California Promise Health, Easy Choice, Health Net, Humana, LA Care, and Molina.

Tax Id: _____ **Phone:** _____

Clinic Name: _____

Clinic Address: _____

Provider Name: _____

Provider Signature: _____ **Date:**_____

You may fax or e-mail the signed attestation to Preferred IPA

Fax: 818-265-0801 Attn: Anita Hacopian

E-mail: ahacopian@preferredipa.com