Alignment Health™

PROVIDER/DELEGATE REPRESENTATIVE CONFIRMATION

Special Needs Plans (SNP) Model of Care Training Confirmation

I, _____, confirm that the Special Needs Plan (SNP) Model of Care (MOC) Training has been distributed via this portal or another appropriate means to the listed Providers. (Includes Dementia Training for CA Providers.)

The listed Provider(s) and I understand the Model of Care and our organization's responsibility in improving health outcomes for our most vulnerable population.

The listed Providers and I also understand this training is required by the Centers for Medicaare and Medicaid Services (CMS) for all Medicare Advantage Providers who care for SNP members.

Training Type **(Select One)** ☐ ANNUAL ☐ ONBOARDING/NEWLY CONTRACTED

State: _____ County: _____

Provider/Representative Name: _____ Date: _____

Medical Group/IPA/Provider Name: _____

NPI: _____ Title: _____

Signature: _____

Please return the completed confirmation and provider roster to:

Alignment Quality Management Department

Email to QualityManagement@ahcusa.com

FAX to 562-207-4617

Alignment Health™

Special Needs Plans (SNP) Model of Care Training Confirmation Roster

The following providers received the annual SNP MOC Training

NPI	Provider Name	MSO	IPA/ VENDOR

*** If there are more than 25 providers, please attach additional pages or a complete provider roster*