



January 2024 Provider Policy and Procedure Manual Annual Update Provider Acknowledgment of Receipt (AOR)

By signing this AOR, I acknowledge that:

I have read and reviewed electronic copies of the following Manuals and Trainings available on [iehp.org](https://www.iehp.org):

- Provider Policy and Procedure Manuals Medi-Cal and IEHP DualChoice (HMO D-SNP) - <https://www.iehp.org/en/providers/provider-manuals>**
- Summary of Effected Changes**
- Benefit Manuals are available to view on State and Federal links provided below:**
 - o **Medi-Cal - <https://mcweb.apps.prd.cammis.medi-cal.ca.gov/publications/manual>**
 - o **IEHP DualChoice (HMO D-SNP) - <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>**
- Electronic Data Interchange (EDI) Manual**
- IPA Delegation Agreement (applicable to IPAs only)**
- IEHP Code of Business Conduct and Ethics**
- IEHP DualChoice (HMO D-SNP) Model of Care Training**
- Compliance Program Training (Fraud, Waste and Abuse (FWA), HIPAA Privacy and Security)**

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 the January 1, 2024 effective date.

<input type="checkbox"/> PCP	<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Specialist	<input type="checkbox"/> Vision	<input type="checkbox"/> CBAS
<input type="checkbox"/> Behavioral Health	<input type="checkbox"/> Direct/ Delegated Ancillary	<input type="checkbox"/> SNF	<input type="checkbox"/> Urgent Care	<input type="checkbox"/> LOA
Clinic/Entity Name (If Applicable): _____				
List of Providers within the Group (Please print)				
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 January 15, 2024

Access and complete the AOR form online located at <https://iehp.org/en/providers/provider-manuals>. E-mail the completed form to providerservices@iehp.org or Fax the completed form to (909) 296-3550 to signify your receipt and review of the Provider Manual and Trainings. For questions, please do not hesitate to contact the IEHP Provider Call Center Team at (909) 890-2054 or (866) 223-4347.