



2027 Provider Policy & Procedure Manuals Annual Update Delegate Acknowledgment of Receipt (AOR)

By signing this AOR, I acknowledge that:

(1) I have read and reviewed electronic copies of applicable Manuals and Trainings:

☐ 2027 Provider Policy and Procedure Manuals:

<https://www.providerservices.iehp.org/en/resources/provider-manuals-and-training/manuals-trainings>

- ☐ Medi-Cal
- ☐ IEHP DualChoice (HMO D-SNP)
- ☐ IEHP Covered

☐ Summary of Effected Changes (All Lines of Business)

☐ IEHP Code of Business Conduct and Ethics

☐ Compliance Program Training (Fraud, Waste and Abuse (FWA), HIPAA Privacy and Security)

☐ IPA Delegation Agreement

☐ IEHP DualChoice (HMO D-SNP) Model of Care Training (*For Delegates serving IEHP DualChoice Members*)

☐ Benefit Manuals:

☐ Medi-Cal - <https://mcweb.apps.prds.cammis.medi-cal.ca.gov/publications/manual>

☐ IEHP DualChoice - <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs.html>

☐ IEHP Covered - www.https://www.iehp.org/en/browse-plans/covered-california#plan-materials

I hereby attest that, to the extent required, all appropriate functional areas, staff and downstream entities/subcontractors, 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, 2027 effective date.

IMPORTANT: IEHP requires a signed attestation from the Delegate's Compliance Officer and/or Administrator ONLY. Please note that AORs without all information below will not be accepted as complete.

Delegate Name:		Date:	
Title:	Name (Please Print):	Signature (Required):	

Please return this signed AOR on or before **January 15, 2027**.

E-mail the completed form to Gonzalez-J6@iehp.org. For any questions do not hesitate to reach out to the Manager of Delegation Oversight at (909) 256-6020 or (909) 296-2925.