



2023 IEHP DualChoice (HMO D-SNP) Model of Care (MOC) for Non-Contracted Providers Acknowledgment of Receipt (AOR)

By signing this AOR, I acknowledge that:

(1) I have read and reviewed electronic copies of the following Trainings:

- D-SNP (HMO D-SNP)_Model of Care Training**

<https://www.iehp.org/en/providers/provider-resources?target=Non-Contracted-Providers>

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 completing this acknowledgement of receipt.

<input type="checkbox"/> PCP	<input type="checkbox"/> OB/GYN	<input type="checkbox"/> Specialist	<input type="checkbox"/> Vision
<input type="checkbox"/> Behavioral Health	<input type="checkbox"/> Direct Ancillary	<input type="checkbox"/> SNF	<input type="checkbox"/> CBAS
Clinic/Entity Name (IF APPLICABLE): _____			
List of Providers within the Group (PLEASE PRINT, does not apply to Direct Ancillary)			
1. _____	5. _____		
2. _____	6. _____		
3. _____	7. _____		
4. _____	8. _____		
Address: _____			
City: _____		State: _____	Zip: _____
Phone: _____		Ext: _____	Fax: _____
Signature (REQUIRED): _____ Date: _____			

Please return your signed AOR within 90 calendar days of receiving this notice.

Fax the completed form to (909) 296-3550, or e-mail the completed form to providerservices@iehp.org, or access the Model Of Care AOR form online located at <https://www.iehp.org/en/providers/provider-resources?target=Non-Contracted-Providers> to signify your receipt and review of the Model of Care training.