Care1st Health Plan

ANNUAL SNP MODEL OF CARE TRAINING ACKNOWLEDGEMENT 2017

Medical Group(s)/Provider:

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(Please write in your Medical Group or Individual Provider Name on the above line)

I acknowledge that I have completed the 2017 annual SNP Model of Care Training.

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Signature

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Print Name

____

License(s)

____

NPI/Tax Id

____

County

____

Date

You may fax or e-mail this signed form to Provider Network Operations:

Fax number: 619-528-4820

E-mail: SDSNPMOC@care1st.com