Provider Attestation for Model of Care Training

_______ I attest that my organization and its contracted providers have received the HMSA Akamai Dual Care Plan Model of Care training. CMS Regulation 42 CFR § 422.102 (f)(2)(ii).

_______ I attest that my organization has established a mechanism for compliance with the provider training requirement.

- Your organization must establish a process for compliance, including but not limited to: dissemination to providers the HMSA Akamai Dual Care Plan MOC training, maintenance of all documentation including rosters, and a process for annual re-training

_______ I attest that within sixty (60) days receipt of this notice, my organization/practice will provide HMSA Akamai Dual Care Plan a roster of all providers/staff who received the training and a signed Attestation for HMSA Akamai Dual Care Plan Model of Care Training.

- Providers that render services for members in the Dual-Special Needs Program (D-SNP) program are required to take the HMSA Akamai Dual Care Plan MOC training.

Signature:________________ Printed Name:________________

Date:____________________ Provider Name:_______________

Email to: AkamaiD-SNP Attestation@hmsa.com

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