Special Needs Plans (SNP) Model of Care Training Attestation Form



l,	, hereby attest that the attached listed providers h	ave
completed the Martin's Point Generation	ons Advantage Special Needs Plan (SNP) Model of Care	е
	nd the Model of Care and the role they play in improving	_
	ation. It is understood that this annual training is mandanbers and is required by the Centers for Medicare and I	_
icaid Services (CMS).	ibers and is required by the centers for recalcule and i	100
Office Representative:	Date:	_
Title:		
Signature:		
Medical Group/ACO/Provider Name:		
TIN:		

Please attest that you have completed training by filling out and returning this form along with the attached provider roster for your practice to Network-Management@MartinsPoint.org.

^{*}Please note that, if completing for a group of physicians under one Tax ID, a record of individual attestations must be recorded and made available upon request by Martin's Point Health Care.

Provider Roster

Purpose: Special Needs Plan (SNP) Model of Care (MOC) annual training is mandatory and required by the Centers for Medicare and Medicaid Services (CMS) for all providers contracted with Medicare Advantage Special Needs Plans.

Instructions: Upon completion of training, in addition to the attestation form, please list each provider's first and last name, National Provider Identification (NPI) number, and the date training was completed. If additional lines are need please attach a spreadsheet.

First and Last Name	NPI	Training Completion Date