

ANNUAL SNP MODEL OF CARE TRAINING
ACKNOWLEDGEMENT 2019

Employee/Provider:

(Please write in your name on the above line)

I acknowledge that I have completed the 2019 annual SNP Model of Care Training.

Signature:

Print Name:

License(s):

NPI/Tax ID:

County

Date:

Participating Health Plan's

- ☐ Care1st
- ☐ Blue Cross/Anthem/Amerigroup
- ☐ Alignment
- ☐ Brand New Day
- ☐ Easy Choice
- ☐ Central
- ☐ Humana
- ☐ Imperial Health Plan
- ☐ Imperial Insurance of Texas

You may Fax or Email this signed form to:

Email: pno@imperialhealthholdings.com

Fax: 626-380-9142