



Provider Newsflash



A fax bulletin for the Molina Healthcare of Washington Provider Network

MODEL OF CARE TRAINING 2019

Centers for Medicare and Medicaid Services (CMS) / Dual enrollees - Mandatory Requirement

As part of required annual training, Molina Healthcare of Washington has developed the Model of Care program for dual eligible enrollees training. The Model of Care serves as the foundation for Molina Healthcare's care management policy, procedures and operational systems for our Medicare/Dual eligible population.

What Providers Need to Do – DEADLINE: OCTOBER 31, 2019

1. Complete training
2. Sign this form
3. Return this form via fax to (425) 424-7110

The form will serve as evidence of completion for your Molina Healthcare Model of Care Provider training.

Where to access Molina Healthcare's Model of Care Training

The training materials can be found on Molina Healthcare's website at MolinaHealthcare.com.

- At the top of the home page, select your State: Use the drop-down arrow and click on your applicable State
- Find the "Health Care Professionals" button: select "Medicare" or "Dual Options" as applicable

Medicare Providers

- You will be redirected to the Medicare Providers home page
- Select Your State: Use the drop-down arrow, then click on your applicable State
- Select Your Plan: Use the drop-down arrow, then click on "Medicare"
- Click "Submit"
- Scroll to the bottom of the web page to the "Model of Care" section

Thank you for your immediate response and cooperation. This training requirement is mandated by CMS and must be performed annually.

If you wish to have specific policies and procedures, you may request them by calling your Molina Healthcare Provider Services representative. You may also access our Care Management program information and Clinical Practice Guidelines through our website at MolinaHealthcare.com.

Sincerely,

Martha Alexander
Program Manager



Model of Care Training Confirmation Calendar Year 2019

I have received and reviewed the written materials for the SNP/MMP Model of Care training.

Print Provider Name: _____

Print Clinic/Practice Name: _____

Clinic/Practice Address: _____

Signature: _____ Date: _____

TIN: _____ NPI: _____