



# Provider Newsflash



A fax bulletin for the Molina Healthcare of Washington Provider Network

## **Model of Care Training 2019 – PAST DUE!** **CMS / Dual Enrollees - Mandatory Requirement**

As part of Centers for Medicare and Medicaid Services (CMS) required annual training, Molina Healthcare of Washington faxed to you the 2019 Model of Care provider training in July 2019. Providers caring for our Medicare/Dual eligible population are asked to complete the training and return the signed attestation below, with a roster that reflects each provider trained to Molina Healthcare. Our records indicate that we have not received the attestation with roster from you to date. **The DEADLINE is: November 30, 2019**

### What you need to do:

1. **Complete training** - take the training at <https://www.molinahealthcare.com/providers/common/medicare/PDF/2019-MOC-Provider-Training.pdf>
2. **Sign this form** (see below)
3. **Return this form with roster** via fax at (425) 424-7110

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

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 in place for the training, you may request them by calling your Molina Healthcare Provider Services representative. To access our Care Management program information and Clinical Practice Guidelines visit: [https://www.molinahealthcare.com/providers/common/medicare/PDF/04\\_2012-20Medicare-20Clinical-20Practice-20Guidelines-201-12.pdf](https://www.molinahealthcare.com/providers/common/medicare/PDF/04_2012-20Medicare-20Clinical-20Practice-20Guidelines-201-12.pdf)

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## **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:** \_\_\_\_\_

**NPI:** \_\_\_\_\_ **TIN:** \_\_\_\_\_ **Date:** \_\_\_\_\_