MOLINA HEALTHCARE

PROVIDER BULLETIN

A bulletin for the Molina Healthcare of Ohio provider networks

Cultural Competency

Providers are required to participate in Molina Healthcare's Cultural Competency education and training. We have resources to assist providers, including translated materials and accessible formats like Braille. For members who are deaf or hard of hearing, call Ohio Relay/TTY at (800) 750-0750 or 711.

To learn more, view our Cultural Competency Disability Awareness & Sensitivity Training at www.MolinaHealthcare.com/OhioProivders by clicking "Provider Training" under the "Manual" tab.

Once the review of the Cultural Competency Training is completed, fill out and sign the "Cultural Competency Attestation" form available at www.MolinaHealthcare.com/OhioProviders by clicking "Provider Training" under the "Manual" tab.

Send the signed and dated form by Dec. 31, 2017:

- Email to OHProviderRelations@MolinaHealthcare.com
- Fax to (866) 713-1894, ATTN: Debbe Snow

Questions?

Provider Services – (855) 322-4079
8 a.m. to 5 p.m., Monday to Friday
(MyCare Ohio available until 6 p.m.)

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MOLINA HEALTHCARE

CULTURAL COMPETENCY TRAINING CONFIRMATION 2017
Centers for Medicare and Medicaid Services (CMS) – **Mandatory Requirement**

Please sign below to attest you have received Cultural Competency training in 2017 from Molina Healthcare. Send the signed and dated form by Dec. 31, 2017:

- Email to OHProviderRelations@MolinaHealthcare.com
- Fax to (866) 713-1894, ATTN: Debbe Snow

Molina Healthcare is required to provide annual Cultural Competency training to our participating provider network. The training is mandated by CMS to ensure providers meet the unique and diverse needs of all members. Thank you for your immediate response and cooperation.

I have received and reviewed the written materials for the Cultural Competency training.

Clinic/Practice Name: _____

Clinic/Practice Address: _____

_____

Group Tax Identification Number (TIN): _____

Signature: _____ Date: _____ State: _____

Physician Information
Please complete for all participating providers in your practice. This information will be available to our members to reference when selecting a provider who meets their cultural needs. A spreadsheet containing this information can be attached, if needed.

Provider Name: _____

Provider Ethnicity (NCQA Requirement): _____

Language(s) Spoken: _____

Provider Name: _____

Provider Ethnicity: _____

Language(s) Spoken: _____

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