Attestation Form

Attestation for Model of Care Training

_____ I attest that my organization and its contracted providers have received the WellCare/ Easy Choice Health Plan Model of Care (MOC) training. (Centers for Medicare and Medicaid (CMS) Regulation **42 CFR §422.102(f)(2)(ii).**

_____ I attest that my organization has established a mechanism for compliance with the provider training requirement.

- Your organization must establish a process for compliance, including but not limited to: dissemination to providers the WellCare / Easy Choice Health Plan MOC training, maintenance of all documentation including rosters, and a process for annual re-training.

_____ I attest that within sixty (60) days receipt of this notice, my organization will provide to WellCare / Easy Choice Health Plan a roster of all providers who received the training and a signed Attestation for WellCare / Easy Choice Health Plan Model of Care Training.

- Providers that render services for members in the Dual-Special Needs Program (D-SNP) program are required to take the WellCare/ Easy Choice Health Plan MOC training.

X

Signature: _____ **Printed Name:** _____

Date: _____ **Organization Name:** _____

Email to : ECProviderAttestations@WellCare.com

Please Fax to: (714) 947-8708