

2021 Cal MediConnect and Dual-Eligible Special Needs Plan Model of Care Training Attestation

Instructions: Complete either the individual or group attestation, and email the completed form to Provider_education@blueshieldca.com.

Individual attestation: Complete this page only and email the completed form to provider_education@blueshieldca.com. If you took the Blue Shield Promise Health Plan eLearning course, your completion has already been recorded and you do not need to submit this form.

I am an individual who has completed the training. By submitting this form, I acknowledge that I have completed the 2021 Cal MediConnect and Dual-Eligible Special Needs Plan Model of Care provider training.

Medical Group(s)/Provider: _____

First Name: _____ Last Name: _____

Email: _____

License #: _____ NPI: _____

County: _____ Date: _____

End of Individual attestation. If you are completing the group attestation, see next page.

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Group attestation: Complete this page and list the providers in your group who have completed the training on the next page(s). Email the completed form and provider list to provider_education@blueshieldca.com.

I am submitting this form for a group who has completed the training. By submitting this form, I acknowledge that the practitioners listed on the following page(s) have completed the 2021 Cal MediConnect and Dual-Eligible Special Needs Plan Model of Care provider training.

Medical Group(s)/Provider: _____

Print Name: _____ Date: _____

Title: _____

Group Tax ID: _____ NPI: _____

County: _____

List the providers in your group who have completed the training on the next page(s).

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List the providers in your group who have completed the training. You may add more pages if needed.

Date	First name	Last name	License #	NPI	Group name	Email