



**El Paso Health Advantage D-SNP Annual Model of Care
Training Attestation**

Medical Group/Provider: _____

(Please write your medical group or individual provider name on the above line)

I acknowledge that I have completed:

- 2021 DSNP Model of Care Training

Signature

Date:

Print Name

NPI/Tax ID

County

You may fax or email this signed form to the Provider Relations Department:

Fax number: 915-225-6762

Email: ProviderServicesDG@elpasohealth.com