



**El Paso Health Medicare Advantage Dual (HMO 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:

- 2025 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**