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:

- 2026 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**