



IMPERIAL HEALTH PLAN
OF CALIFORNIA

COMPLIANCE, FWA, HIPAA, SNP MODEL OF CARE TRAINING ATTESTATION FORM

The below provider/entity acknowledges that the Imperial Health Plan of California, Inc. Compliance Training and Education, which includes training on Compliance, FWA, HIPAA and IHP SNP Model of Care (MOC) training, has been accessed via <https://www.imperialhealthplan.com> and read under the Provider section of the website. It is understood that it is a network providers' obligation to read and become familiar with these trainings and follow regulatory requirements.

By signing the below, the signor is certifying that the contents of the referenced materials below have been reviewed and agrees to abide by all regulatory requirements and processes outlined in these documents.

<input type="checkbox"/> Initial Training	<input type="checkbox"/> Annual Training
<input type="checkbox"/>	General Compliance training
<input type="checkbox"/>	Fraud Waste and Abuse training
<input type="checkbox"/>	HIPAA training
<input type="checkbox"/>	SNP Model of Care (MOC) training

Please Print:

Organization/Practice Name: _____

Group NPI: _____

Physician Name: _____	NPI: _____
Physician Name: _____	NPI: _____
Physician Name: _____	NPI: _____
Physician Name: _____	NPI: _____

(If necessary, please attach additional sheets, including organization/practice name, group NPI, physician name and NPI)

By signing this form, I attest that the forementioned trainings have been received, reviewed. I acknowledge all information and obligation of compliance are understood.

Print Name: _____

Signature: _____

Title: _____

Date: _____

Please return completed, signed attestation by fax to the attention of Provider Network at (626) 689-4230.