

**Annual Model of Care (MOC)  
Attestation Form**

<b>Delegate Name:</b>	<b>Scripps Health Plan Services</b>
<b>Full Name:</b>	
<b>Title:</b>	
<b>E-Mail:</b>	
<b>Date Completed</b>	
<b>Time Completed</b>	

**Annual MOC Training**

I attest that I completed the Annual MOC Training on the date and time noted above.

I understand the MOC training module is accessible to me:

- Directly on SCAN's website at [SNP Model of Care Training \(scanhealthplan.com\)](http://scanhealthplan.com)
- Direction on HealthNet's website at [Provider Medicare Training & Marketing Guides | Health Net \(www.healthnet.com\)](http://www.healthnet.com)
- On our website at [Provider Resources \(scrippshealthplanservices.com\)](http://scrippshealthplanservices.com)
- In the Scripps Health Plan Services Provider Manual
- In the Quarterly Provider Newsletter.

Signature	Printed Name
Title	Date

E-Mail Completed Attestation to [SHPSCCMLeadership@scrippshealth.org](mailto:SHPSCCMLeadership@scrippshealth.org).