Medicare Advantage Plan

Nascentia Health PLUS

Model of Care Training Attestation of Completion

Attestation of Completion:

By signing below, I attest to the fact that the provider(s) listed have received and reviewed the 2024 Nascentia Health Plus Model of Care (MOC) training and understand the obligation to comply with the program requirements. Additionally, this will confirm I hold the authority to make this attestation.

Select type of Model of Care Training completed:	☐	Nascentia Dual Advantage Special Needs Plan (D-SNP)
	☐	Nascentia Skilled Nursing Facility Special Needs Plan (I-SNP)
	☐	Nascentia Dual Advantage Special Needs Plan (D-SNP) and Nascentia Skilled Nursing Facility Special Needs Plan (I-SNP)

Date of Completion:					
Print Provider / Practice Name:					
Street Address:					
City:		State:		Zip Code:	
Phone Number:	( )		Tax ID:		
Signature:					
Printed Name:			Title:		

If you are completing this attestation on behalf of a group of providers, please list each provider below or attach a spreadsheet with the following information.

1. Provider Name:			
Practice / Group TIN:		Individual NPI:	
2. Provider Name:			
Practice / Group TIN:		Individual NPI:	
3. Provider Name:			
Practice / Group TIN:		Individual NPI:	
4. Provider Name:			
Practice / Group TIN:		Individual NPI:	