**CHOC Health Alliance Provider Training Attestation**

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| **Provider/Practice Name:** | | **NPI:** |
|  | |  |
| **Group Tax ID:** | **Specialty:** | **License #:** |
|  |  |  |
| **Contract Effective Date:** | **Line of Business:** | **Provider Relations Rep:** |
|  | Medi-Cal |  |

**Training Topics**

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| **Medi-Cal Program** | |
| Early Periodic Screening, Diagnosis and Testing (EPSDT) | Individual Health Education Behavioral Assessment (IHEBA) Requirement |
| Electronic Visit Verification (EVV) Requirements |  |

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| **CalOptima Health Network Operations** | |
| CalOptima Health Programs and Initiatives (includes Whole Child Model and CalAIM) | Medical Management Delegation & Payment Responsibility |
| Long-Term Support Services (LTSS) | Community-Based Adult Services (CBAS) |
| Critical Incident Reporting | Fraud, Waste, and Abuse (FWA) Training |
| Behavioral Health Services | Dementia Care Aware Training |
| Member Rights & Responsibilities | Member Benefits |
| Member Grievance and Appeals Process | Provider Communications |
| CalOptima Health Policies and Procedures | Responsibilities for IHCP & American Indian Members |

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| **CHOC Health Alliance Operations** | |
| Provider Manual | Access Standards |
| Model of Care | Seniors and Persons with Disabilities Training |
| Cultural Competency Training including Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex, and Asexual (LGBTQIA+) | Provider Cultural and Linguistic Requirements |
| Medi-Cal Member Eligibility Determination and Verification Process | Medical Management and Authorization Requirements |
| Prior Authorization Process | Utilization Management Appeals and Provider Dispute Resolution Process |
| Doula Services | Claims Submission and Payment |
| Coordination of Benefits and Covered Services | Conflict Resolution |
| Member Billing Restrictions | Quality Improvement for Health Services Programs |

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| **Annual In-Service** | |
| Program Overview | Fraud, Waste and Abuse (FWA) Training |
| Cultural Competency Training | Disability Awareness Training |
| EPSDT Training |  |

*By signing I attest that CHA provided training and resources, available through CHA and CalOptima Health, on the above information.*

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| **Print Name** |  | **Training Completion Date** |  |
| **Signature** |  | **Date Signed** |  |