HEALTHCOSMOS
MEDICAL GROUP, LLC

HealthCosmos Medical Group

ANNUAL SNP MODEL OF CARE TRAINING ACKNOWLEDGEMENT

Employee/Provider:

_____

(Please write in your Name on the above line)

I acknowledge that I have completed the 2022 Annual SNP Model of Care Training.

Signature:

_____

Print Name:

_____

License(s):

_____

NPI/Tax ID:

_____

County

_____

Date:

Participating Health Plan's

□ SCAN
□ Amerigroup

You may Fax or Email this signed form to:

HealthCosmos AZ Provider Network Department Email	HealthCosmos NV Provider Network Department Email
pno@healthcosmosaz.com	pno@healthcosmosnv.com
Fax: (214) 452-1190	Fax: (214) 452-1190