**El Paso Health Medicare Advantage Dual (HMO D-SNP)**
**Annual Model of Care Training Attestation**

Medical Group/Provider: _____
(Please write your medical group or individual provider name on the above line)

I acknowledge that I have completed:

- 2026 DSNP Model of Care Training

_____
Signature Date:

_____
Print Name

_____
NPI/Tax ID

_____
County

_____

**You may fax or email this signed form to the Provider Relations Department:**
**Fax number:915-225-6762** **Email:ProviderServicesDG@elpasohealth.com**