



## Model of Care (MOC) Training Attestation

Required for providers participating in Hamaspik Medicare plans (D-SNP, MAP) under 42 CFR 422.101(f). Complete one attestation per contracted Tax ID (TIN), signed by an authorized representative on behalf of all affiliated practitioners and clinical staff.

| SECTION 1   PROVIDER / ORGANIZATION INFORMATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                                                                                                                                  |                            |  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|--|
| Legal Entity / Organization Name *                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                                                                                                                                  |                            |  |
| Tax ID (TIN) *                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                                                                                                                                  | Group / Facility NPI       |  |
| Provider Type (check one) *                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | <input type="checkbox"/> Delegated Entity / IPA <input type="checkbox"/> Medical Group / Practice<br><input type="checkbox"/> Individual Practitioner <input type="checkbox"/> Ancillary / Other |                            |  |
| Number of Practitioners Covered by this Attestation *                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                                                                                                                                  | Individual NPI (solo only) |  |
| Practitioner Name(s) or attach roster (required for groups of 10 or more)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                                                                                                                                  |                            |  |
| Roster Attached                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A (Individual practitioner)                                                                                  |                            |  |
| SECTION 2   TRAINING DETAILS                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                                                                                                                                  |                            |  |
| Training Type *                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | <input type="checkbox"/> Initial (new to network)<br><input type="checkbox"/> Annual                                                                                                             | Date Completed *           |  |
| SECTION 3   ATTESTATION                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                  |                            |  |
| <p>By signing below, I attest that:</p> <p>(1) I am authorized to sign on behalf of the organization identified above;</p> <p>(2) the practitioners and clinical staff affiliated with this Tax ID who provide services to Hamaspik Medicare members have received and reviewed Hamaspik's Model of Care training for the training year indicated;</p> <p>(3) they understand their responsibilities under the Model of Care, including care coordination and participation in the Interdisciplinary Care Team (ICT) as appropriate;</p> <p>(4) for delegated entities, the training has been distributed to the full sub-network and completion is documented; and</p> <p>(5) records supporting this attestation will be retained and made available to Hamaspik, CMS, or the New York State Department of Health upon request.</p> |                                                                                                                                                                                                  |                            |  |
| Authorized Representative Name *                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                                                                                                                                  |                            |  |
| Title *                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                  |                            |  |
| Email *                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                                                                                                                                  | Phone *                    |  |
| Signature (electronic or typed signature accepted) *                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                                                                                                                                  |                            |  |
| Date Signed *                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                                                                                                                                                                                  |                            |  |

**Thank you for your participation!**

Please email the completed attestation (and roster/completion report, if applicable) to:

[providerrelations@hamaspikchoice.org](mailto:providerrelations@hamaspikchoice.org)

Or submit your attestation online: [Hamaspik MOC Training Attestation](#)