Model of Care Attestation

☐ I hereby attest that I have received the Gold Kidney Health Plan 2023 Model of Care Provider training

Please indicate the method in which you received the MOC training (Required)

◉ Reviewed enclosed printed MOC training materials ○ Received training in person from a Gold Kidney Health Plan associate or training seminar ○ Completed the interactive on-line MOC training module

Provider, Group or Facility Name (Required)

Tax ID Number (Required)

Providers Name(s) (Required)

Authorized Representative's Signature (Required)

Date (Required)

This field is required.