Connections Provider Orientation Package

Attestation Form

This is to acknowledge that I have received a copy or read the SCAN Connections Provider Orientation Package (POP). I understand as part of SCAN’s Connection provider network, I may be caring for dual eligible (Medicare/Medi-Cal) members and the Connections Provider Orientation Package (POP) contains important information on SCAN’s policies, procedures, rules, regulations, and benefits that will provide guidance. I also acknowledge that it is my responsibility to familiarize myself and share with my staff the Connections Provider Orientation Package (POP).

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| --- | --- |
| Provider Name (Please Print):  | Provider Organization Name:  |
| Provider/Group Tax ID Number:  | Provider/Group NPI Number: |
| Email Address: | Phone Number: |
| Office Manager: | Office Manager Phone Number:  |

Provider/Office Manager Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Please return completed and signed attestation within 4 business days of receipt to our general mailbox NetworkManagementAdministration@scanhealthplan.com or by fax to 562-308-4447.

Should you have any question, you may contact our Network Management Admin Specialist at NetworkManagementAdministration@scanhealthplan.com.

Thank you,

SCAN Network Management