January 2019 Annual Update
Provider Acknowledgment of Receipt (AOR)

Please complete the following information in order to receive future updates to the IEHP Provider Policy and Procedure Manual. By signing this AOR, I acknowledge that I have received and read a CD-ROM that includes an electronic copy of the following Manuals and Trainings:

1. **Policy and Procedure Manuals** Medi-Cal and IEHP DualChoice
2. **Summary of Effected Changes**
3. **IEHP Code of Business Conduct and Ethics**
4. **Guidelines for Care Management Training**
5. **Compliance Program Training** (Fraud, Waste and Abuse (FWA) HIPAA Privacy and Security)
6. **Cultural and Linguistic (C & L) Training**

I hereby attest that, to the extent required, all appropriate staff have received and/or been trained on the information contained in the documents listed above. I attest that the undersigned entity/organization has established and publicized compliance policies and procedures, standards of conduct, and compliance reference material that meet the requirements outlined in 42 CFR §422.503(b)(4)(vi), 42 CFR §423.504(b)(4)(vi), and 42 CFR §438.608(a)(1).

Submitted by Mail: Susie White, Provider Services Department
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☐ PCP ☐ OB/GYN ☐ Specialist ☐ Vision ☐ Behavioral Health ☐ Direct Ancillary

Clinic/Entity Name **(IF APPLICABLE):** ____________________

List of Providers within the Group **(PLEASE PRINT, does not apply to Direct Ancillary)**

1. ____________________ 5. ____________________

2. ____________________ 6. ____________________

3. ____________________ 7. ____________________

4. ____________________ 8. ____________________

Address: ____________________

City: ____________________ State: ______ Zip: ____________________

Phone: ____________________ Ext: ________ Fax: ____________________

Signature **(REQUIRED)**: ____________________ Date:____________________

Please return your signed AOR on or before <u>January 7, 2019</u>