SAN FRANCISCO HEALTH PLAN™

Here for you

New Provider Training Attestation Form

By signing below, I___________________________attest that I have received materials and training on the following subjects:

- About the SFHP Provider Network
- Key Contacts
- SFHP Programs
- Eligibility
- Access to Care
- Referrals, Prior Authorization, and Appeal to UM Decisions
- Member Rights, including the right to full disclosure of healthcare information and the right to actively participate in healthcare decisions
- Member Complaints and Grievances
- Medi-Cal Benefits
- Initial Health Assessment (IHA)
- Staying Healthy Assessment (SHA)
- Coordination of Care for Medi-Cal Members
- DHCS Waiver Programs
- Health Education
- Cultural and Linguistics Training
- Seniors and Persons with Disabilities Training

____ ________________________

Signature Date

____

Print Name

____

Address, City, St, Zip