Date:

RE: **Provider Training**

This letter is to ensure that (PPG/Network Provider) Name:_____is confirming that the 2020 Provider Training has been conducted within the required 10 working days after the PPG/Network Provider has been placed on an active status with (RBO/MSO) Name_____.

Please check the appropriate boxes below and include the evidence of training and completed documentation with 2020 Provider Training.

RBO/MSO Response:

I_____(Name of PPG/Network Provider representative) attest that (RBO/MSO Name)_____has conducted Provider Network training on the following subjects:

- ☐ Medi-Cal Managed Care Program
- ☐ Member Rights
- ☐ Member Services
- ☐ Evidence-Based Practice Guidelines (specific to RBO/MSO)
- ☐ Clinical Protocols (specific to RBO/MSO)
- ☐ Cultural Awareness and Sensitivity

I_____(Name of PPG/Network Provider representative) attest that (RBO/MSO Name)_____ also provides the following:

- ☐ Ongoing Training
- ☐ Updated Information on Website (e.g., Policies & Procedures, etc.)

Response provided by:
Signature:_____Date:_____
Phone number:_____Email address: _____

Sincerely,

Blue Shield of California Promise Health Plan Delegation Operations Department