





CONFIRMATION OF NEW PROVIDER TRAINING

Please complete the following and submit it via email to <u>Professional.Relations@MHN.com</u> or send it via fax to 1-866-225-7106.

REQUIRED: Initial #1 OR #2		
1 (initial) I have received the new provider training materials from Managed Health Network (MHN) and CalViva Health, reviewed them for training purposes, and understand essential components of CalViva Health's Medi-Cal plan, including basic information about public health programs available to CalViva Health Medi-Cal members, the plan's quality improvement program, and interpreter services and provider tools to care for diverse populations.		
OR		
 (initial) I have completed Managed Health Network (MHN) and CalViva Health's Medi-Cal managed care training online on the provider website and understand essential components of CalViva Health's Medi-Cal plan, including basic information about public health programs available to CalViva Health Medi-Cal members, the plan's quality improvement program, and interpreter services and provider tools to care for diverse populations. REQUIRED: Initial #3		
Provider name (PRINT)	Provider signature	Date (MM/DD/YYYY)
Provider address (street, city, ZIF)	
Phone number	Email address	Tax identification number (TIN)
INTERNAL USE ONLY		
Received date	ved date Data entry date (MM/DD/YYYY) Provider representative	