Gold Coast Health Plan℠
A Public Entity

Integrity • Accountability • Collaboration • Trust • Respect

TRAINING ATTESTATION PROVIDER LIST FORM

Thank you for completing the provider training. Please use this form to submit a list of all participating providers and staff. You may submit multiple copies of this form as needed.

For questions, contact ProviderRelations@goldchp.org.

Training Information:

Training Name: _____ Date(s) of Training: _____

Submitted By:

Name: _____ Email: _____

Provider List: Please provide the names and NPI numbers of all participating providers and staff.

Name (First and Last)	NPI#

Certification: I certify that the above information is accurate and complete.

Provider Representative Signature: _____ **Date:** _____