The Contractor attests its compliance with the AHCCCS network standards for each county(ies) in which they operate as specified in the AHCCCS Medicaid Contract and AHCCCS Policy.

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| --- |
| **NETWORK ATTESTATION STATEMENT**  **FROM** |
| **CONTRACTOR NAME**  **HEALTH PLAN ID** |
| **CONTRACT YEAR ENDING**  **TO** |

**THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM**

**DIVISION OF HEALTH CARE SERVICES, OPERATIONS**

I hereby attest that the Network Development and Management Plan submitted **does not meet** the Network Standards identified in ACOM Policy 415, ACOM Policy 436, and in Contract for the following county(ies):

**(LIST EACH COUNTY)**

I hereby attest that the Network Development and Management Plan submitted **meets** all Network Standards identified in ACOM Policy 415, ACOM Policy 436, and in Contract for the following county(ies):

**(LIST EACH COUNTY)**

|  |  |  |
| --- | --- | --- |
|  |  |  |
| ***(Network Administrator or Designee Signature)*** |  | ***Date*** |
|  |  |  |
| ***(Printed Name of Network Administrator or Designee)*** |  | ***Date*** |