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

**NETWORK ATTESTATION STATEMENT**

**FROM**

**CONTRACTOR’S NAME**

**HEALTH PLAN ID**

**CONTRACT YEAR ENDING**

**TO**

**THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM**

**DIVISION OF HEALTH CARE MANAGEMENT, OPERATIONS**

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

  **(LIST EACH COUNTY)**

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(Network Administrator Signature)  
(Date)

(Ported Name of Network Administrator)