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.

|  |
| --- |
| **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*** |