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*** |