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 (AHCCCS)
DIVISION OF ~~HEALTH CARE SERVICES,~~ MANAGED CARE [1] 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***

[1] Revised to update the division name.

Effective Dates: 10/01/13, 03/01/14, 10/01/15, 07/01/16, 10/01/17, 10/01/18, 10/01/19, 10/01/20, 10/01/21, 10/01/22, 10/01/23, 10/01/24, 10/01/25, 10/01/26
Approval Dates: 03/30/17, 11/02/17, 06/21/18, 06/06/19, 04/23/20, 06/01/21, 05/17/22, 06/22/23, 05/16/24, 05/01/25, 05/06/26