P.O. Box 64882, St. Paul, MN 55164-0882  
Telephone: 651-201-5100

Email: [health.managedcare@state.mn.us](mailto:health.managedcare@state.mn.us)

# Network Adequacy Attestation Document

## Name and Title of Person Submitting this Document:

| Carrier, Name Network, Network ID |  |
| --- | --- |
| Name |  |
| Title |  |
| Date |  |

## Instructions:

Respond **Yes** or **No** to each of the attestations below and provide a signature to the Network Adequacy Attestation Document. Responses of **No** to any of the below attestations must be addressed through a justification provided in the attached Supplemental Response Form. Justifications will be reviewed by the Minnesota Department of Health (MDH) on a case-by-case basis in review of this form. If the applicant provides **Yes** responses to all attestations, the Supplemental Response Form is not required.

## Network Attestations:

1. Applicant attests that it will maintain a network that is sufficient in number and types of providers to assure that all services will be accessible without unreasonable delay.

Yes No

1. Applicant attests that this filing complies with all applicable State network adequacy standards.

Yes No

1. Applicant attests that network data provided is representative of signed contracts in place, and that all data submitted is accurate and current as of the date of filing.

Yes

No

| Signature | Date |
| --- | --- |

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# Attestation Justification Supplemental Response Form

[Issuer] is providing this supplemental response to the Minnesota Department of Health (MDH) in order to offer justification for providing a response of No to an attestation listed in the Network Adequacy Attestation Document. In submitting this Supplemental Response Form, the Applicant notes that MDH maintains discretion to accept this justification as adequate and may ask for additional documentation if necessary.

| **Attestation** | **Response (Yes/No)** | **Justification/Clarification** |
| --- | --- | --- |
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