

(Company Letter Head)

**Attestation of Provider Network Submission**

Date\_\_\_\_\_

I, \_\_\_\_\_, as (Title) for (Name of Company), do hereby attest that the information provided concerning our proposed network (letters of intent and/or subcontracts) is (are) accurate, true, and complete.

I attest that the necessary information for these providers will be loaded into our organization's system prior to providing services to Louisiana Medicaid/CHIP members. Additionally, I attest that the following requirements will be met:

- All subcontracts and amendments will utilize a model sub contract approved by DHH, or any modifications to the model subcontract have been approved by DHH prior to execution,
- All subcontracts will be properly signed, dated and executed by both parties, and
- All provider files will contain information regarding hospital privileges (if appropriate) and a list of group practice members.

In addition to the services provided through its subcontracted network, \_\_\_\_\_ (DBP name) will provide access consistent with the Contract with DHH.

I understand that should DHH determine at a later date that the submitted information is inaccurate, untrue, or incomplete, (Name of company) may be subject to sanctions and/or fines as outlined in the Contract with DHH.

\_\_\_\_\_  
Signature/Title

\_\_\_\_\_  
Date