LOUISIANA DEPARTMENT OF HEALTH

**Medicaid MCO Provider Network Attestation for 348 Report**

CONTRACTOR: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Contractor hereby attests that the information it has provided in the accompanying 348 Report is accurate and true. By signing this form, the Contractor attests its compliance (or a deficiency as noted below) with the LDH network standards for each Parish in which it operates as delineated in the LDH Medicaid Contract and the LDH Report 348 template.

* I hereby attest that our MCO provider network, as reflected in this report and in our provider registry and provider directory, fully **meets** the LDH MCO Network Standards identified in Report 348 and in the Contract for each of the 67 parishes.
* I hereby attest that our provider network, as reflected in this report and in our Provider Registry and Provider Directory, fully meet the LDH MCO Network Standards identified in Report 348 and in Contract for each of the 67 parishes except for the following parish(es) for which the provider network does not fully meet the Network Standards.
1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 3.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Etc.

(LIST EACH PARISH)

In each Parish listed above that does not fully meet the Network Standards identified in Report 348, for each of the noted provider network deficiencies, the Contractor agrees to provide all medically necessary state plan covered services within the prescribed time and distance requirements via out-of-network providers until such services are available in network and if there are no local providers the Contractor will cover transportation and lodging to an appropriate provider until such time as these services are available within prescribed time and distances;

In each Parish listed above that does not fully meet the Network Standards identified in Report 348, for each of the noted provider network deficiencies, the Contractor agrees to submit a proposed quarterly work plan and related monthly reports to LDH on the Contractor's progress and results related to the specific tasks undertaken to address network deficiencies.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Network Administrator Signature) Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Printed Name/Title of Network Administrator)

Contact information (email/phone)