Network Adequacy Attestation For Use of Approved Network

(Complete this form if an insurer is using the same network as approved by the New York State Department of Health (DOH) in the same counties)

Name of Insurer

Name of Network

Network Approval Check the applicable box about the Provider Network identified above and provide the requested information.

☐ This network is the same as the network approved by DOH and will be used for the same counties.

☐ This network is the same as the network approved by NYSOH and will be used for the same counties.

Identify the approved network below. If approved by DOH, indicate the name or ID as approved by DOH. For networks approved by NYSOH, use the network ID as found in the Network Template on the Plan Management tab for the NYSOH approved binder.

Network Name **Network ID** **Approval Date**

Counties in Approved Network List each county in the approved network. (Add rows if needed.)

I attest the above information is true, accurate and complete to the best of my knowledge. I understand that any falsification, omission or concealment of material fact may subject the insurer to civil penalties.

Signature of Officer **Print Name and Title of Company Officer** **Date**