(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 provider files will contain a list of group practice members.

In addition to the services provided through its subcontracted network, _____ (DBPM 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