New York State Department of Health and Department of Financial Services
Network Adequacy and Access Standards for Behavioral Health Services
Annual Certification

Instructions:

1. Each licensed Company must complete and submit a separate certification and access complaint spreadsheet.
2. Identify the Company and NAIC number and list the applicable line(s) of business below.
3. Complete the attached spreadsheet listing each access complaint received between December 1 of the prior calendar year and November 30 of the current calendar year. For example, for the certification due by December 31, 2026, the reporting period would be December 1, 2025 through November 30, 2026.
4. The certification must be signed by an officer of the Company.
5. By December 31st of each year, submit the certification and spreadsheet to the Department of Financial Services (DFS) at health@dfs.ny.gov, and/or the Department of Health (DOH) at bmccsmail@health.ny.gov, as appropriate. Insurers should direct their responses to DFS, and MCOs should direct their responses to DOH. If a Company is submitting one certification for its insurance and HMO coverage, it should provide the response to both DOH and DFS.

Name of the Company, NAIC Number, and the lines of business (use the numbers below to identify the lines of business):

Company Name: _____ NAIC Number: _____

Line of Business: _____ Line of Business: _____ Line of Business: _____

Line of Business: _____ Line of Business: _____ Line of Business: _____

Line of Business: _____ Line of Business: _____ Line of Business: _____

Line of business: (1) Medicaid Managed Care; (2) Child Health Plus: (3) Essential Plan; (4) Commercial HMO coverage (Certified under PHL Article 44); (5) Commercial PHSP coverage (Certified under PHL Article 44); (6) Commercial (Insurer authorized to write accident and health insurance in New York); (7) Commercial (Corporation authorized pursuant to IL Article 43); (8) Commercial (Student health plan certified pursuant to IL § 1124); and (9) Commercial (Municipal cooperative health benefit plan certified pursuant to IL Article 47).

Certifying Officer's Information

Name: _____

Title: _____

Phone Number: _____

Email Address: _____

Business Address: _____

City: _____ State: _____ Zip Code: _____

Certification

Important: DOH and DFS are relying upon this certification as part of the review of your Company's compliance with 10 NYCRR 98-5 and/or 11 NYCRR 38. Should it be determined that this certification is materially false, incomplete, or incorrect, appropriate enforcement action may be taken. Acceptance of this certification by DOH or DFS is not a determination of compliance with the regulation(s).

I, _____, declare, affirm and certify under penalty of perjury, that the information entered as part of this certification is true to the best of my knowledge and belief and that:

1. I have undertaken due diligence and conducted all reasonable inquiry prior to making any of the statements in this certification and have sufficient knowledge to complete this certification,

2. the Company listed above has adopted, implemented, and maintains network adequacy and access standards for behavioral health services that meet the requirements of 10 NYCRR 98-5 and/or 11 NYCRR 38, including:

    a. the Company has an access plan as required and such access plan is available upon the superintendent's request;

    b. the Company has sufficient participating providers in each network used by the Company to meet the appointment wait time standards as required; or in instances where there are not sufficient participating providers to meet the appointment wait time standards as required, the Company allows insureds to obtain behavioral health services from non-participating providers; and

    c. the Company has performed the provider directory verification required by the regulation;

3. the Company listed above has completed the attached Access Complaint spreadsheet completely and accurately, summarizing all access complaints received between December 1 of the prior calendar year and November 30 of the current calendar year, including information related to:

    a. the number of access complaints received;

    b. a description of how the access complaints were resolved;

    c. the behavioral health services requested in each access complaint;

    d. the geographic area of the state where the services were requested in each access complaint;

    e. the number of approved referrals to non-participating providers made during the prior twelve months; and

    f. the number of referrals that the Company did not approve and the reasons why the Company did not approve the referrals;

4. the Company listed above maintains complete documentation regarding the actions that form the basis for this certification, which shall be made available to DOH and DFS upon request; and

5. the Certifying Officer and the Company acknowledges that this certification is being made to comply with the requirements of 10 NYCRR 98-5 and/or 11 NYCRR 38.

Signature:

Certifying Officer's Signature	Date