P.O. Box 64882, St. Paul, MN 55164-0882  
Telephone: 651-201-5100

Email: [health.managedcare@state.mn.us](mailto:health.managedcare@state.mn.us)

# 2024 Enrollment Attestation Document

## Name and Title of Person Submitting this Document:

| Carrier Name | | |
| --- | --- | --- |
| Respondent Name | Title | Date |

## Instructions:

Please report total 2024 Minnesota enrollment, corresponding to total enrollment reported in Exhibit 1 - 2024 Enrollment by Product Type for Health Business Only (column 5) submitted with your 2024 Annual Statement.

1. Carrier attests its 2024 Minnesota Enrollment (total members) as of December 31, 2024, is

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Or

1. Carrier attests that it had no 2024 Minnesota enrollment.

Yes

No

| Signature | Date |
| --- | --- |

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# Attestation Justification Supplemental Response Form

[Issuer] is providing this supplemental response to the Minnesota Department of Health (MDH) in order to offer justification for providing a response of No to an attestation listed in the Network Adequacy Attestation Document. In submitting this Supplemental Response Form, the Applicant notes that MDH maintains discretion to accept this justification as adequate and may ask for additional documentation if necessary.

| **Attestation** | **Response (Yes/No)** | **Justification/Clarification** |
| --- | --- | --- |
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