LETTER OF INTENT TO ENTER INTO CONTRACT NEGOTIATIONS FOR PROVISION OF SERVICES TO KANSAS MEDICAID AND CHIP MEMBERS

This letter may be subject to review or approval by the Kansas Department of Health and Environment, Division of Health Care Finance (the "Department").

The Department is requesting proposals from qualified managed care organizations ("MCOs") seeking to establish a risk-based, capitated contract with the Department for providing and managing the health care services for certain Kansas Medicaid and CHIP beneficiaries ("Members").

WellCare of Kansas, Inc. ("WellCare") is part of a group of companies operating health insurance plans under Medicare, Medicaid and CHIP programs in several states, and is making application to be a Kansas licensed health insurer. WellCare may contract with the Department as an MCO.

By signing below, you indicate your intention to enter into an agreement with WellCare for the provision of health care services to Members enrolled with WellCare if WellCare is awarded a contract by the Department. Such an agreement will apply to your current service area(s), and any other areas you list in the Attachment to this Letter of Intent.

Signing this Letter of Intent does not obligate you to sign a contract with WellCare.

This Letter of Intent may be used by the Department in its bid evaluation and contract award process. You consent to WellCare's inclusion of your information as part of WellCare's proposal to the Department. You should only sign this Letter of Intent if you intend to enter into contract negotiations with WellCare should WellCare receive a contract award. Please complete all portions of this Letter of Intent and its Attachment.

Please fax completed Letter of Intent to (314) 444-7575 and mail an original to:

WellCare of Kansas, Inc.
ATTN: Network Development
133 S. 11th Street
Suite 200
St. Louis, MO 63102

1. **PROVIDER'S SIGNATURE** _____

2. **DATE** _____

3. **PRINTED NAME OF SIGNER** _____

4. **TITLE OF SIGNER** _____

5. **PRINTED NAME OF PROVIDER OR PRACTICE NAME**
   _____
   (*if different from signer*)

ATTACHMENT TO LETTER OF INTENT: PROVIDER INFORMATION

1. Kansas License Number _____
2. National Provider Identifier (NPI) _____
3. Medicaid Provider Identification Number (if any) _____
4. Provider's Printed Name _____
5. Address(es) Where Services To Be Provided (or attach practice roster)

   _____
6. Zip Code _____
7. City, County, State _____
8. Telephone _____
9. Fax _____
10. Provider Type (e.g., physician, hospital, pharmacy, community mental health center, dentist, optometrist or ophthalmologist, freestanding laboratory, home health, public health department, freestanding radiology, general behavioral health provider, FQHC, RHC, APRN, PA, freestanding psychiatric hospital, psychiatric residential treatment facility).

    _____
11. PCP _____ Specialist _____ If PCP: Open Panel _____ Closed Panel _____
12. Areas of Provider Primary and Secondary Specialty, if any

    _____
13. Ages Seen _____
14. Service(s) To Be Provided To Members (note any differences by provider site)

    _____
15. Languages Spoken By Provider (other than English) _____
16. Name of Hospital(s) Where Physician Has Admitting Privileges

    _____