LETTER OF INTENT

Joint Healthy Options and Basic Health Programs

This Letter of Intent ("LOI") shall set forth certain understandings between the providers set forth at Attachment A hereto ("Provider") and Coordinated Care Corporation (“Plan”) with respect to the execution of a participating provider agreement ("Provider Agreement") for the provision of services (“Covered Services”) to enrollees of the Healthy Options and Basic Health Programs (“Joint Healthy Options and Basic Health Program").

1) Provider(s) agrees to timely enter into a mutually agreeable Provider Agreement as defined herein with Plan to provide Covered Services as required by the State of Washington, Health Care Authority (“HCA”) to individuals enrolled in or assigned to Plan by the HCA as part of the Joint Healthy Options and Basic Health Program. Provider acknowledges and agrees that this LOI shall be superseded by the Provider Agreement to be finalized by the parties.

2) Provider consents to the listing of Provider's name and address in a prototype Coordinated Care Corporation provider directory for the Joint Healthy Options and Basic Health Program; provided, however, that any listing of Provider's name and address shall be accompanied by a notation that Provider's listing is based upon an LOI entered into between Plan and Provider.

3) The parties acknowledge that Plan’s license to do business as a Managed Care Organization (“MCO”) in the state of Washington is currently pending.

4) This LOI shall be construed and interpreted in accordance with the laws of the state of Washington.

This LOI is solely for the benefit of the parties hereto and will not be construed to give rise to or create any liability or obligation to, or to afford any claim or cause of action to, any other person or entity. This LOI will be superseded in its entirety by the provisions of the Provider Agreement upon the execution and delivery thereof.

Entity/Group/Provider (Please sign and complete the information below and on the next page).

Signature: _____

Name: _____

Title: _____

Address: _____

Telephone: _____

E-Mail: _____

Fax: _____

Date: _____

ATTACHMENT A

(This form may be duplicated if additional copies are needed)

Participating Providers (PLEASE TYPE OR PRINT)

Group Practice Name: _____

Provider Name: _____

Primary Specialty *(check applicable category)*:

- ☐ Family Practice
- ☐ Obstetrics
- ☐ Ophthalmology
- ☐ Pulmonology
- ☐ Pediatrics
- ☐ Internal Medicine
- ☐ Cardiology
- ☐ Gastroenterology
- ☐ Physiatry
- ☐ Orthopedic Surgery
- ☐ General Surgery
- ☐ Oncology
- ☐ Otolaryngology
- ☐ Neurology
- ☐ Other

Secondary Specialty *(if applicable)*:

- ☐ Family Practice
- ☐ Obstetrics
- ☐ Ophthalmology
- ☐ Pulmonology
- ☐ Pediatrics
- ☐ Internal Medicine
- ☐ Cardiology
- ☐ Gastroenterology
- ☐ Physiatry
- ☐ Orthopedic Surgery
- ☐ General Surgery
- ☐ Oncology
- ☐ Otolaryngology
- ☐ Neurology
- ☐ Other

Primary Service Site *(must not be a PO Box)*:

City: _____ State: _____ Zip: _____ County: _____

Phone: _____ Fax: _____ E-Mail: _____

Office Contact Name: _____

Office Contact Email: _____

Tax ID #: _____ WA License #: _____

Medicaid #: _____ Provider NPI #: _____

CAQH #: _____ Group NPI # *(if applicable)*: _____

If services are provided at more than one location, please list the addresses of those additional service sites below. Please do not list PO Box addresses.

1) _____

2) _____

3) _____

4) _____

Are you a PCP, Specialist or BOTH? ☐ PCP ☐ Specialist ☐ BOTH

If a PCP, is your panel Open or Closed? ☐ Open ☐ Closed

Provider Type *(check applicable category)*:

- ☐ Physician (MD or DO only)
- ☐ Hospital (Acute Care only)
- ☐ Pharmacy
- ☐ Dentist
- ☐ FQHC
- ☐ RHC
- ☐ Public Health Department
- ☐ Physician Assistant (PA)
- ☐ Free Standing Radiology
- ☐ Home Health
- ☐ Free Standing Laboratory
- ☐ Other Ancillary Provider
- ☐ Advanced Practice Registered Nurse (APRN)
- ☐ Optometrist or Ophthalmologist
- ☐ Free Standing Psychiatric Residential
- ☐ Psychiatric Residential Treatment Facility
- ☐ Community Mental Health Center
- ☐ All Other Behavioral Health