LETTER OF INTENT TO CONTRACT WITH
AMERIHEALTH CARITAS RHODE ISLAND
FOR

THE PROVISION OF SERVICES TO RHODE ISLAND RESIDENTS ENROLLED IN A FEDERAL DEMONSTRATION PROGRAM

AmeriHealth Caritas Rhode Island ("ACRI") a member of the AmeriHealth Caritas Family of Companies, is currently developing a network of hospital, physician, ancillary and skilled nursing facility healthcare providers. ACRI has begun the process of qualifying to contract with the Rhode Island Executive Office of Health and Human Services/Medicaid (RI Medicaid) and the Centers for Medicare and Medicaid Services ("CMS") to arrange for the delivery of health care services to individuals who are concurrently eligible for Medicare and Medicaid and enrolled in a federal demonstration program ("Demonstration Program").

Please sign below and complete the Provider Information Attachment to indicate your intent to enter into contract negotiations with ACRI for the provision of health care services to Demonstration Program recipients who enroll with ACRI if it enters into a contract to arrange for the provision of services under the Demonstration Program. Providing specific information regarding your practice(s) and/or facility will help ACRI demonstrate provider network adequacy as well as provide you with the appropriate provider contracts in the near future. This Letter of Intent is non-binding; signing this Letter of Intent does not obligate you to sign a contract with ACRI.

By signing this Letter of Intent, you agree to allow ACRI to identify you to RI Medicaid, CMS and the Rhode Island Department of Business Regulation ("DBR") as a potential provider in the ACRI provider network. ACRI will not otherwise identify you as being affiliated in any manner with ACRI until you have signed a definitive provider agreement with ACRI.

RI Medicaid and DBR may use this Letter of Intent to evaluate ACRI's qualification to offer and sponsor the Demonstration Program. Please also be advised that this Letter of Intent may be subject to review or approval by RI Medicaid, CMS or DBR and may be amended by ACRI to comply with the requirements of any and/or all of these agencies.

Please fax the signed Letter of Intent and completed Provider Information Attachment to 888-498-8751. Contact 888-987-5826 with questions

Provider Name: _____

Authorized Signature: _____

Printed Name: _____

Title: _____

Date: _____

AMERIHEALTH CARITAS RHODE ISLAND
LETTER OF INTENT

PROVIDER INFORMATION ATTACHMENT

Section 1: Provider Information

Provider Group/Facility Name: _____

Business Name *(if different than provider name):* _____

Business Address: _____

Service/Practicing Location(s) with ZIP Code(s): _____

_____

Number of Unique Providers at Each Service/Practicing Location(s)
(attach list for multiple locations or contact 888-987-5826 for an electronic Provider Information Attachment form) _____

Section 2: Provider Professional/Medical Specialty Information

Primary Specialty: _____

Secondary Specialty: _____

Professional Degree: _____

Are You A Primary Care Provider(s)? ☐**Yes** ☐**No** *(use attached for multiple providers)*

Are You Accepting New Patients? ☐ **Yes** ☐ **No**

Are You A Specialist Provider(s): ☐ **Yes** ☐ **No** *(attach list for multiple providers)*

Are You Accepting New Patients? ☐ **Yes** ☐ **No**

Provider/Facility Contact Person: _____

Phone: _____

Fax: _____

Email: _____