LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS – MEDICAID PROGRAM
Dental Benefit Program RFP – Letter of Intent for Providers
305PUR-DHHRFP-DBP-P-MVA

The attached Letter of Intent (LOI) template and associated information is provided for the benefit of proposers seeking participation in the Louisiana Department of Health and Hospitals (DHH) Dental Benefit Program (DBP) program. Do not send completed Letters of Intent to DHH or Louisiana Medicaid unless requested.

Letter of Intent Instructions

The LOI is to be used to show a provider's intention to enter into a contract to provide Medicaid covered dental services within a proposer's network, should that proposer be successful in securing a DBP contract with DHH. Providers that commit through the LOI should be prepared to provide services at the anticipated DBP launch date, March 1, 2013.

No alterations or changes to this LOI are permitted, except for shaded areas which identify the proposer. The proposer may print the form on their letterhead or insert their name or logo at the top of the form. Completed LOIs or executed contracts will be acceptable as evidence of a providers proposed network and will be used to determine network adequacy.

If a representative signs an LOI on behalf of a provider, evidence of authority for the representative must be available upon request from DHH.

LETTER OF INTENT TO CONTRACT WITH
_____
FOR PROVISION OF SERVICES TO LOUISIANA MEDICAID RECIPIENTS THROUGH COORDINATED CARE NETWORKS

No alterations to this letter are permitted. The information provided is subject to verification by DHH.

The provider signing below is willing to enter into contract negotiations with _____ for the provision of Medicaid covered services to Louisiana Medicaid recipients enrolled in the Dental Benefit Plan with _____. The undersigned provider intends to contract with _____ if _____ is awarded a contact with the Louisiana Department of Health & Hospitals (DHH) for the Dental benefit Program to serve the following region on the anticipated start date of March 1, 2013, if an acceptable agreement can be reached between the provider and _____.

Signing this letter of intent does not obligate the provider to sign a contract with _____. This is not a contract. This Letter of Intent may be used by DHH in its bid evaluation and contract award process for the Dental Benefit Program RFP. If you are signing on behalf of a physician, please provide evidence of your authority to do so.

Do not return the completed Letter of Intent to DHH. Completed Letters of Intent need to be returned to _____.

Provider: _____

Provider Signature:

_____

Date: _____

Printed Name of Provider:

_____

Title: _____

Proposer: _____

Proposer Representative Signature:

_____

Date: _____

Printed Name of Proposer Representative:

_____

Title: _____

ADDITIONAL PROVIDER AND SERVICES INFORMATION

FOR LETTER OF INTENT
FOR PROVISION OF SERVICES TO LOUISIANA MEDICAID RECIPIENTS
THROUGH THE DENTAL BENEFIT PALN

Section 1 – Provider Information

Provider Name: _____
Actual dentist name

Business Name: _____
If different from provider name

Provider's Street Address/es:
*Provider must provide **street address** (no post office boxes) and parish for each location. Include all sites where services will be provided. Use additional paper as needed.*

Location (street address): _____
_____
Parish: _____

Location (street address): _____
_____
Parish: _____

Location (street address): _____
_____
Parish: _____

Location (street address): _____
_____
Parish: _____

Main Provider Contact:
First Name: _____
Middle: _____
Last Name: _____

Phone: _____ **Fax:** _____
E-mail: _____

State License Number: _____
State Issuing License Number: _____
Medicaid ID Number: _____
National Provider ID: _____
Federal Employer Identification Number: _____

Section 2 – Provider Professional/Dental Specialty Information

Primary Specialty: _____

_____

Secondary Specialty: _____

_____

Limits *(age, adults only, etc.):* _____

_____

Professional Degree: _____

Language (other than English): _____

Provider Provides Pediatric Care? *Yes* ____ *No* ____

Provider is:

Primary Care Only ____
Specialty Care Only ____
Both Primary and Specialty Care ____