

LOUISIANA DEPARTMENT OF HEALTH AND HOSPITALS – MEDICAID PROGRAM
Coordinated Care Network RFP – Letter of Intent for Providers
305PUR-DHHRFP-CCN-P-MVA (Prepaid) and 305PUR-DHHRFP-CCN-S-MVA (Shared Savings)

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) Coordinated Care Network (CCN) program. Additional instructions regarding this LOI will be provided in the CCN RFP and supporting guides when they are released. Only the instructions included in the RFP and its supporting guides are considered official. 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 services within a proposer's network, should that proposer be successful in securing a CCN contract with DHH. Providers that commit through the LOI should be prepared to provide services at the CCN launch date based on the regional phase-in schedule as follows:

- January 1, 2012 - Regions 9 and 1
- March 1, 2012 – Regions 2, 3 and 4
- May 1, 2012 - Regions 5, 6, 7 and 8

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
PROPOSER NAME
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 PROPOSER NAME for the provision of Medicaid covered services to Louisiana Medicaid recipients enrolled in a Coordinated Care Network with PROPOSER NAME. The undersigned provider intends to contract with PROPOSER NAME if PROPOSER NAME is awarded a contract with the Louisiana Department of Health & Hospitals (DHH) for a Coordinated Care Network to serve the following region on the indicated start date (check all that apply) if an acceptable agreement can be reached between the provider and PROPOSER NAME:

- Region 1 (New Orleans)– January 1, 2012
- Region 2 (Baton Rouge) – March 1, 2012
- Region 3 (Thibodaux) – March 1, 2012
- Region 4 (Lafayette) – March 1, 2012
- Region 5 (Lake Charles) – May 1, 2012
- Region 6 (Alexandria) – May 1, 2012
- Region 7 (Shreveport) – May 1, 2012
- Region 8 (Monroe) – May 1, 2012
- Region 9 (Northshore) – January 1, 2012

Signing this letter of intent does not obligate the provider to sign a contract with PROPOSER NAME. This is not a contract. This Letter of Intent may be used by DHH in its bid evaluation and contract award process for the Coordinated Care Networks 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 PROPOSERS NAME AND ADDRESS.

Provider: _____

Proposer: _____

Provider Signature:

Proposer Representative Signature:

Date: _____

Date: _____

Printed Name of Provider:

Printed Name of Proposer Representative:

Title: _____

Title: _____

ADDITIONAL PROVIDER AND SERVICES INFORMATION

*FOR LETTER OF INTENT
FOR PROVISION OF SERVICES TO LOUISIANA MEDICAID RECIPIENTS
THROUGH COORDINATED CARE NETWORKS*

Section 1 – Provider Information

Provider Name: _____
Actual physician 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/Medical Specialty Information

Primary Specialty: _____

Secondary Specialty: _____

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

Professional Degree: _____

Language (other than English): _____

Provider Provides Obstetrical Care? Yes _____ No _____

Provider Provides Pediatric Care? Yes _____ No _____

Provider is:

Primary Care Only _____

Specialty Care Only _____

Both Primary and Specialty Care _____