

The following information is provided as early notification for Offerors' benefit. However, complete instructions regarding this Letter of Intent will be provided when the RFP is released. Only instructions included in the RFP are considered official. Do not send completed Letter of Intent to AHCCCSA at this time.

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### **Letter of Intent Instructions**

The following is the mandated format for the Arizona Health Care Cost Containment System, Contract Year Ending 2004, Letter of Intent (LOI). It is to be used to show a provider's intention to enter into a contract with an Offeror. No alterations or changes are permitted, except for shaded areas which identify the Offeror. The Offeror's name or logo may be inserted in the box at the top of the forms. The completed LOI or an executed contract will be acceptable evidence of an Offeror's proposed network. For purposes of the RFP, no scoring distinction will be made between an LOI and executed contracts.

If a provider has multiple sites that offer identical services, only one LOI should be signed, with additional service site information (items 1 to 6) attached to the LOI. If services differ between sites, a separate LOI must be obtained for each service site.

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

OFFEROR'S  
NAME

Please do not sign this Letter of Intent unless you seriously intend to enter into negotiations with the health plan mentioned below.

No alterations or changes are permitted, except for shaded areas which identify the Offeror. This letter is subject to verification by the Arizona Health Care Cost Containment System Administration (AHCCCSA).

The provider signing below is willing to enter into contract negotiations with (Offeror's name), for provision of covered services to AHCCCS members enrolled with (Offeror's name). This provider intends to sign a contract with (Offeror's name) if (Offeror's name) is awarded an AHCCCS contract beginning October 1, 2003 in the provider's service area and an acceptable agreement can be reached between the provider and (Offeror's name). Signing this Letter of Intent does not obligate the provider to sign a contract with (Offeror's name) however, please do not sign this Letter of Intent unless you seriously intend to enter into negotiations with the above mentioned health plan.

The following information is furnished by the provider:

1. AHCCCS PROVIDER IDENTIFICATION NUMBER \_\_\_\_\_
2. PROVIDER'S PRINTED NAME \_\_\_\_\_
3. ADDRESS (where services will be provided) \_\_\_\_\_  
\_\_\_\_\_ ZIP CODE \_\_\_\_\_
4. COUNTY \_\_\_\_\_ 5. TELEPHONE \_\_\_\_\_ 6. FAX \_\_\_\_\_

\_\_\_ Please check here if additional service site information is attached to the Letter of Intent

7. CHECK ALL THAT APPLY

- \_\_\_ A. Primary Care Physician      \_\_\_ Family Practice      Services \_\_\_ EPSDT  
   \_\_\_ General Practice     \_\_\_ OB  
   \_\_\_ Pediatrics  
   \_\_\_ Internal Medicine

- \_\_\_ B. Primary Care Nurse Practitioner      \_\_\_ Family Practice      Services: \_\_\_ EPSDT  
   \_\_\_ Adult     \_\_\_ OB  
   \_\_\_ Pediatrics  
   \_\_\_ Midwife

- \_\_\_ C. Primary Care Physician's Assistant      Services: \_\_\_ EPSDT  
   \_\_\_ OB

- \_\_\_ D. Physician – Specialist – (Specify) \_\_\_\_\_  
\_\_\_ E. Hospital  
\_\_\_ F. Urgent Care Facility  
\_\_\_ G. Pharmacy  
\_\_\_ H. Laboratory  
\_\_\_ I. Medical Imaging  
\_\_\_ J. Medically Necessary Transportation  
\_\_\_ K. Nursing Facility  
\_\_\_ L. Dentist  
\_\_\_ M. Therapy (Specify Physical Therapy, Occupational Therapy, Speech, Respiratory) \_\_\_\_\_  
\_\_\_ N. Behavioral Health Provider (Specify) \_\_\_\_\_  
\_\_\_ O. Durable Medical Equipment  
\_\_\_ P. Home Health Agency  
\_\_\_ Q. Other (Please Specify) \_\_\_\_\_

OFFEROR'S  
NAME

8. LANGUAGES SPOKEN BY THE PROVIDER (OTHER THAN ENGLISH) \_\_\_\_\_  
\_\_\_\_\_

9. NAME OF HOSPITAL(S) WHERE PHYSICIAN HAS ADMITTING PRIVILEGES \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**NOTICE TO PROVIDERS:** This Letter of Intent will be used by AHCCCSA in its bid evaluation and contract award process. You should only sign this Letter of Intent if you intend to enter into contract negotiations with (Offeror's name) should they receive a contract award. If you are signing on behalf of a physician, please provide evidence of your authority to do so.

*Do not return completed Letter of Intent to AHCCCSA. Completed Letter of Intent needs to be returned to (Offeror's name).*

10. PROVIDER'S SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

11. PRINTED NAME OF SIGNER \_\_\_\_\_ TITLE \_\_\_\_\_

OFFEROR'S  
NAME

**ADDITIONAL SERVICE SITES**

- 1. AHCCCS PROVIDER IDENTIFICATION NUMBER \_\_\_\_\_
- 2. PROVIDER'S PRINTED NAME \_\_\_\_\_

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- 3. ADDRESS (where services will be provided) \_\_\_\_\_  
\_\_\_\_\_ ZIP CODE \_\_\_\_\_
  - 4. COUNTY \_\_\_\_\_ 5. TELEPHONE \_\_\_\_\_ 6. FAX \_\_\_\_\_

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\_\_\_\_\_ ZIP CODE \_\_\_\_\_
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- 4. COUNTY \_\_\_\_\_ 5. TELEPHONE \_\_\_\_\_ 6. FAX \_\_\_\_\_