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 AHCCCS at this time.

Letter of Intent Instructions

The following is the mandated format for the Arizona Health Care Cost Containment System, Contract Year Ending 2007 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 may print the form on its letterhead or insert its name or logo 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.
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/Logo

Please do not sign this Letter of Intent unless you seriously intend to enter into negotiations with the Offeror mentioned below and understand that the Arizona Health Care Cost Containment System Administration (AHCCCS) requires all contracts to include Minimum Subcontract Provisions as listed at http://www.azahcccs.gov/Contracting/BidderLib_Acute.asp.

No alterations or changes are permitted, except for shaded areas which identify the Offeror. This letter is subject to verification by AHCCCS.

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, 2008 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. NATIONAL PROVIDER IDENTIFICATION NUMBER (NPI) or 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 ___ General Practice ___ Pediatrics ___ Internal Medicine	Services:	___ EPSDT ___ OB
___ B. Primary Care Nurse Practitioner	___ Family Practice ___ Adult ___ Pediatrics ___ Midwife	Services:	___ EPSDT ___ OB
___ 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

Offeror's Name/Logo

___ 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)____

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 AHCCCS 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 AHCCCS. Completed Letter of Intent needs to be returned to (Offeror's name).

10. PROVIDER'S SIGNATURE ___________________________________DATE _______________

11. PRINTED NAME OF SIGNER ________________________________TITLE _______________

ADDITIONAL SERVICE SITES:

1. NATIONAL PROVIDER IDENTIFICATION NUMBER (NPI) or AHCCCS PROVIDER IDENTIFICATION NUMBER ______________________________

2. PROVIDER'S PRINTED NAME ______________________________

3. ADDRESS (where services will be provided) ______________________________
______________________________ZIP CODE______________________________

4. COUNTY ________________ 5. TELEPHONE ________________ 6. FAX ________________

3. ADDRESS (where services will be provided) ______________________________
______________________________ZIP CODE______________________________

4. COUNTY ________________ 5. TELEPHONE ________________ 6. FAX ________________

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