LETTER OF INTEREST TO ENTER INTO CONTRACT NEGOTIATIONS WITH SHA, L.L.C. d/b/a FirstCare and/or Southwest Life & Health Insurance Company FOR PROVISION OF SERVICES TO HHSC Medicaid-STAR and CHIP MEMBERS

This letter is subject to verification by the Texas Health and Human Services Commission (HHSC). A Provider should not sign this Letter of Interest unless the Provider intends to enter into contract negotiations with SHA, L.L.C. d/b/a FirstCare and/or Southwest Life & Health Insurance Company (FirstCare) for the provision of services to Medicaid or CHIP members. Signing this Letter of Interest does not obligate the Provider to sign a contract with for the provision of services to Medicaid or CHIP Members.

The provider signing below is willing to enter into contract negotiations with FirstCare, for the provision of managed health care services to Medicaid and CHIP members enrolled with FirstCare as indicated below.

This provider intends to sign a contract with FirstCare in all currently awarded service areas and any future service areas awarded to FirstCare in the Service Areas applicable to the provider and an acceptable agreement can be reached between the provider and FirstCare.

NOTICE TO PROVIDERS:
This Letter of Interest may be used by HHSC in its bid evaluation and contract award process for the RFP for Managed Care Services for all Service Areas. You should only sign this Letter of Interest if you intend to enter into contract negotiations with FirstCare should FirstCare 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 Interest to HHSC. Completed Letter of Interest needs to be returned to

FirstCare Health Plans
ATTN: CONTRACTING
12940 N. HWY 183
Austin, Texas 78750

1. **PROVIDER'S SIGNATURE** ______________________
2. **DATE** ______________________
3. **PRINTED NAME OF SIGNER** ______________________
4. **TITLE OF SIGNER** ______________________
5. **PRINTED NAME OF PROVIDER** (IF DIFFERENT FROM SIGNER)

   ____
6. **RESPONDENT REPRESENTATIVE'S SIGNATURE**

   ____
7. **DATE** ______________________
8. **PRINTED NAME OF SIGNER** ______________________
9. **TITLE OF SIGNER** ______________________

ADDITIONAL PROVIDER AND SERVICES INFORMATION FOR LOI BETWEEN PROVIDERS AND RESPONDENTS FOR PROVISION OF SERVICES TO HHSC Medicaid and CHIP MEMBERS

1. HHSC PROVIDER IDENTIFICATION NUMBER, if any

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2. PROVIDER'S PRINTED NAME

____

3. ADDRESS (where services will be provided)

____

4. ZIP CODE ____________________
5. COUNTY ____________________
6. TELEPHONE ____________________
7. FAX ____________

___ Check here if additional service site information is attached.

8. PROVIDER TYPE (e.g. PCP, OB/GYN, acute care hospital, inpatient mental health facility, Therapy (PT, OT, ST), etc.)

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9. SERVICE(S) TO BE PROVIDED TO MEMBERS, NOTE ANY DIFFERENCES IN TYPES OF SERVICE(S) BY PROVIDER SITE.

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10. AREAS OF PROVIDER SPECIALTY, IF ANY

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11. LANGUAGES SPOKEN BY THE PROVIDER (OTHER THAN ENGLISH)

____

12. NAME OF HOSPITAL(S) WHERE PHYSICIAN HAS ADMITTING PRIVILEGES

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