LETTER OF INTENT TO CONTRACT WITH AMERIHEALTH CARITAS FOR THE PROVISION OF SERVICES TO KENTUCKY MEDICAID-ELIGIBLE RECIPIENTS

AmeriHealth Caritas Kentucky, Inc. ("AmeriHealth Caritas") is currently developing a network of hospital, physician, and ancillary health care providers in order to qualify as a Commonwealth of Kentucky managed care organization, with the goal of entering into a contract with the **Cabinet for Health and Family Services, Department for Medicaid Services (CHFS-DMS)** to arrange for the delivery of health care services to individuals under the CHFS-DMS managed care program to serve the Commonwealth of Kentucky's Medicaid population.

Please sign below to indicate your intent to enter contract negotiations with AmeriHealth Caritas for participation in its provider network for the provision of health care services to the Commonwealth of Kentucky Medicaid-eligible recipients who will be enrolled with AmeriHealth Caritas if we enter a contract with CHFS-DMS. Please complete the Provider Information Sheet. Providing information regarding your practice(s) and/or facility will help AmeriHealth Caritas demonstrate provider network adequacy as well as provide you with the appropriate provider contracts in the near future. This Letter of Intent is non-binding; signing this Letter of Intent does not obligate you to sign a contract with AmeriHealth Caritas. Either you or AmeriHealth Caritas can terminate this Letter of Intent at any time by notifying the other party in writing.

By signing this Letter of Intent, you agree to allow AmeriHealth Caritas to identify you to CHFS-DMS and to the Kentucky Department of Insurance ("KDI") as a potential provider in the AmeriHealth Caritas provider network. AmeriHealth Caritas will not otherwise identify you as being affiliated in any manner with AmeriHealth Caritas until you have signed a definitive provider agreement with AmeriHealth Caritas. CHFS-DMS and KDI may use this Letter of Intent to evaluate AmeriHealth Caritas' qualification as a health maintenance organization to participate in CHFS-DMS' Medicaid managed care program. Provider(s) identified below is/are Kentucky Medicaid providers.

Please check all boxes that apply:

☐ Provider Identified below is a Kentucky Medicaid provider

☐ Provider is not currently a Kentucky Medicaid provider but intends to apply

☐ Provider Identified below is a Medicare provider

☐ Provider is not currently a Medicare provider but intends to apply

I wish to participate in the following applicable programs:

☐ AmeriHealth Caritas Kentucky Medicaid Program

☐ AmeriHealth Caritas Exchange Product

☐ AmeriHealth Caritas Medicare

Please review, sign, and return both pages of the LOI to my attention.

P.O. Box 48, Danville, IN 46122
www.amerihealthcaritas.com

AmeriHealth Caritas™
Kentucky

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Note: This LOI may be subject to review or approval by CHFS-DMS and may be amended by AmeriHealth Caritas Kentucky to comply with the requirements of CHFS-DMS and KDI.

PROVIDER INFORMATION SHEET

Contract Legal Entity name:	
Entity primary taxonomy code:	Entity tax ID number:
Entity National Provider Identification (NPI) number:	NPI not applicable: ☐ Yes ☐ No
Waiting for NPI: ☐ Yes ☐ No	
Kentucky Medicaid number:	Medicare number:
Group NPI:	Specialty type:
Primary contact name/title:	
Entity mailing address:	
Primary contact email:	
Phone number:	
Authorized signature of provider:	
Printed name:	Date:
Title:	