LETTER OF INTEREST TO ENTER INTO CONTRACT NEGOTIATIONS WITH
AMERIGROUP Texas, Inc. d/b/a AMERIGROUP Community Care
FOR PROVISION OF SERVICES TO HHSC HMO 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 AMERIGROUP Texas, Inc. d/b/a AMERIGROUP Community Care ("AMERIGROUP") 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 AMERIGROUP for the provision of services to Medicaid or CHIP Members.

AMERIGROUP is proposing to participate in the STAR Kids Program in all the Service Areas. The provider signing below is willing to enter into contract negotiations with AMERIGROUP, for the provision of managed health care services to HMO members enrolled with AMERIGROUP as indicated below.

This provider intends to sign a contract with AMERIGROUP if AMERIGROUP is awarded a HMO contract in the Service Areas applicable to the provider and an acceptable agreement can be reached between the provider and AMERIGROUP.

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 AMERIGROUP should AMERIGROUP 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 AMERIGROUP at the following address: AMERIGROUP Community Care, Attn: TX Credentialing 3800 Buffalo Speedway, Ste 400, Houston, TX 77098.

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
1. HHSC PROVIDER IDENTIFICATION NUMBER, if any

____________________________________________________________________________________

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)

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

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