LETTER OF INTENT TO ENTER INTO CONTRACT NEGOTIATIONS WITH UNITEDHEALTHCARE COMMUNITY PLAN 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 Intent unless the Provider intends to enter into contract negotiations with UnitedHealthcare Community Plan for the provision of services to STAR Kids Members. Signing this Letter of Intent does not obligate the provider to sign a contract with UnitedHealthcare Community Plan for the provision of services to STAR Kids Members.

UnitedHealthcare Community Plan is proposing to participate in the STAR Kids Program in the all Service Areas. The provider signing below is willing to enter into contract negotiations with UnitedHealthcare Community Plan, for the provision of long term support services to HMO members enrolled with UnitedHealthcare Community Plan as indicated below.

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

NOTICE TO PROVIDERS:
This Letter of Intent 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 Intent if you intend to enter into contract negotiations with UnitedHealthcare Community Plan 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 HHSC. Completed Letter of Intent needs to be returned to UnitedHealthcare Community Plan, 14141 Southwest Freeway, Suite 800, Sugar Land, TX 77474 ATTN: LTSS Provider Relations

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/LOA  
BETWEEN PROVIDERS AND UNITEDHEALTHCARE COMMUNITY PLAN  
FOR PROVISION OF SERVICES TO HHSC HMO MEMBERS  

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. Provider Attendant Services (PAS), Transitional Assistance Services (TAS), etc.)  
____________________________________________________________________________  

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

10. AREAS OF PROVIDER SPECIALTY, IF ANY  
____________________________________________________________________________  

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