LETTER OF INTENT TO ENTER INTO CONTRACT NEGOTIATIONS
FOR PROVISION OF SERVICES TO KENTUCKY MEDICAID MEMBERS

This letter may be subject to review or approval by the Kentucky Cabinet for Health and Family Services, Department for Medicaid Services (the “Department”).

The Department is requesting proposals from qualified managed care organizations (“MCOs”) seeking to establish a risk-based, capitated contract with the Department for providing and managing the health care services for certain Kentucky Medicaid beneficiaries (“Members”).

WellCare Health Insurance of Illinois, Inc. (“WHIIL”) is a Kentucky licensed health insurer. WHIIL and/or an affiliate (“WellCare”) may contract with the Department as an MCO.

By signing below, you indicate your intention to enter into an agreement with WellCare for the provision of health care services to Members enrolled with WellCare if WellCare is awarded a contract by the Department. Such an agreement will apply to your current service area(s), and any other areas you list in the Attachment to this Letter of Intent.

Signing this Letter of Intent does not obligate you to sign a contract with WellCare.

This Letter of Intent may be used by the Department in its bid evaluation and contract award process. You consent to WellCare’s inclusion of your information as part of WellCare’s proposal to the Department. You should only sign this Letter of Intent if you intend to enter into contract negotiations with WellCare should WellCare receive a contract award. Please complete all portions of this Letter of Intent and its Attachment.

Please fax completed Letter of Intent to (877) 338-3745 (toll free) and mail an original to WellCare Health Plans, Inc., Attn: Network Development, 211 Perimeter Center Parkway, Suite 800, Atlanta, GA 30346.

1. PROVIDER’S SIGNATURE ________________________________
2. DATE ________________________________
3. PRINTED NAME OF SIGNER ________________________________
4. TITLE OF SIGNER ________________________________
5. PRINTED NAME OF PROVIDER OR PRACTICE NAME
   ____________________________________________
   (if different from signer)
ATTACHMENT TO LETTER OF INTENT: ADDITIONAL PROVIDER INFORMATION

1. Kentucky License Number _________________________
2. National Provider Identifier (NPI) _________________________
3. Medicaid Provider Identification Number (if any) _________________________
4. Provider’s Printed Name _________________________
5. Address(es) Where Services To Be Provided (or attach practice roster)
   ______________________________________________________
6. Zip Code _________________________
7. City, County, State _________________________
8. Telephone _________________________
9. Fax _________________________
10. Provider Type (e.g., physician, hospital, pharmacy, community mental health center, dentist, optometrist or ophthalmologist, freestanding laboratory, home health, public health department, freestanding radiology, general behavioral health provider, FQHC, RHC, APRN, PA, freestanding psychiatric hospital, psychiatric residential treatment facility).
   __________________________________________________________________________________
11. PCP _____ Specialist _____ If PCP: Open Panel _____ Closed Panel _____
12. Areas of Provider Primary and Secondary Specialty, if any
   __________________________________________________________________________________
13. Ages Seen _________________________
14. Service(s) To Be Provided To Members (note any differences by provider site)
   __________________________________________________________________________________
15. Languages Spoken By Provider (other than English) _________________________
16. Name of Hospital(s) Where Physician Has Admitting Privileges
   __________________________________________________________________________________