LETTER OF INTENT TO ENTER INTO CONTRACT NEGOTIATIONS
FOR PROVISION OF SERVICES TO MISSISSIPPI MEDICAID AND CHIP MEMBERS

This Letter of Intent may be subject to review or approval by the Mississippi Division of Medicaid (the "Department").

The Department is or will be 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 its Medical Assistance Program for certain Mississippi Medicaid eligible beneficiaries ("Members").

WellCare Health Plans, Inc. ("WellCare") offers Medicare, Medicaid and Children's Health Insurance Program health plans through its subsidiaries in several states. WellCare, through a subsidiary, intends to obtain the license(s) to contract with the Department as an MCO (the "WellCare MCO").

By signing below, you indicate your intention to enter into a network participation agreement with the WellCare MCO to provide health care services to Members if it 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 network participation agreement with the WellCare MCO.

This Letter of Intent may be used by the Department in its bid evaluation and contract award process. You hereby consent to the WellCare MCO's inclusion of your information as part of its proposal to the Department. Please complete all portions of this Letter of Intent and its Attachment.

Please email or mail the completed and signed Letter of Intent to:

Email: NetworkExpansion@wellcare.com

Mailing Address: WellCare Health Plans, Inc.
Attention: Network Development
PO Box 31409
Tampa, FL 33633-0029

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*)

WellCare

ATTACHMENT TO LETTER OF INTENT: PROVIDER INFORMATION

1. State 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
    _____