

**SAMPLE PROVIDER LETTER OF INTENT (LOI) TO CONTRACT
AND SAMPLE LETTER OF AGREEMENT (LOA) TO CONTRACT**

Letter of Intent and Letter of Agreement Instructions:

The following two pages depict the mandatory information that a Respondent must include in its Provider Letter of Intent (LOI) and Provider Letter of Agreement (LOA), respectively, for the HHSC RFP for Managed Care Services for the _____ Service Areas. This information is mandatory for any LOIs or LOAs signed after the date on which these LOI/LOA formats are posted on the HHSC website, as indicated by the date in the header of this document. A Respondent may also include additional information in its LOI or LOA forms.

The LOI and LOA must clearly show a provider's intention, (LOI), or a provider's agreement, (LOA), to enter into a contract with a Respondent for the provision of services to HHSC HMO Members if the Respondent is awarded an applicable HHSC HMO Contract by HHSC.

The completed LOI, LOA, or an executed contract, will be acceptable evidence of a Respondent's proposed Network for purposes of the RFP. No scoring distinction will be made between an LOI, an LOA, or an executed contract. HHSC will not require Respondents to submit provider LOIs or LOAs with the Proposal, but the Respondent must make copies of such executed LOIs and LOAs available to HHSC upon request.

If a provider has multiple sites that offer identical services, only one LOI or LOA should be signed, with additional service site information attached to the LOI or LOA. If services differ between sites, the LOI or LOA, or attachments to such documents, must clearly indicate the services at each site to be offered by the provider to HHSC HMO Members enrolled with the Respondent.

If a representative signs an LOI or an LOA on behalf of a provider, evidence of authority for the representative must be available to HHSC upon request.

Respondents should complete the bracketed information in the LOI or LOA, as applicable to the Respondent's Proposal.

In addition to the mandatory information in the one page LOI and LOA formats, a Respondent must collect the additional provider and services information, (numbered items 1 through 12), for each LOI and LOA between a provider and the Respondent for provision of services to HHSC HMO Members as indicated in the last page of this file, entitled, "ADDITIONAL PROVIDER AND SERVICES INFORMATION FOR LOI/LOA BETWEEN PROVIDERS AND RESPONDENTS FOR PROVISION OF SERVICES TO HHSC HMO MEMBERS."

**LETTER OF INTENT TO ENTER INTO CONTRACT NEGOTIATIONS WITH
[The Respondent]
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 [Respondent's name] for the provision of services to _____ Members. Signing this Letter of Intent does not obligate the provider to sign a contract with [Respondent's name] for the provision of services to _____ Members.

[Respondent's name] is proposing to participate in the _____ Program in the _____ Service Areas. The provider signing below is willing to enter into contract negotiations with [Respondent's name], for the provision of _____ services to HMO members enrolled with [Respondent's name] as indicated below.

This provider intends to sign a contract with [Respondent's name] if [Respondent's name] is awarded a HMO contract in the Service Areas applicable to the provider and an acceptable agreement can be reached between the provider and [Respondent's name].

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 the _____ Service Areas. You should only sign this Letter of Intent if you intend to enter into contract negotiations with (Respondent's name) 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 [Respondent's name and address.]

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

**LETTER OF AGREEMENT TO CONTRACT WITH
[The Respondent]
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 Agreement unless the Provider seriously intends to enter into a contract with [Respondent's name] for the provision of services to _____ Members. Signing this Letter of Agreement obligates the provider to sign a contract with [Respondent's name] for the provision of services to _____ Members.

[Respondent's name] is proposing to participate in the _____ Program in the _____ Service Areas. The provider signing below agrees to contract with [Respondent's name], for the provision of services to members enrolled with [Respondent's name] as indicated below.

This provider intends to sign a contract with [Respondent's name] if [Respondent's name] is awarded a STAR+PLUS HMO contract in the Service Area(s) applicable to the provider.

NOTICE TO PROVIDERS:

This Letter of Agreement may be used by HHSC in its bid evaluation and contract award process for the RFP for Managed Care Services for the _____ Service Areas. You should only sign this Letter of Agreement if you agree to contract with (Respondent's name) 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 Agreement to HHSC. Completed Letter of Agreement needs to be returned to [Respondent's name and address].

1. PROVIDER'S SIGNATURE

2. DATE

3. PRINTED NAME OF SIGNER

4. TITLE

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 RESPONDENTS
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. PCP, OB/GYN, acute care hospital, inpatient mental health facility, Therapy (PT,OT, ST), 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)

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