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 Dental Services for the [Medicaid/CHIP] Program. This information is mandatory for any LOIs or LOAs signed after the date 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 intent (via the LOI), or a provider's agreement (via the LOA) to enter into a contract with a Respondent for the provision of services to HHSC Dental Services Members if the Respondent is awarded an HHSC Dental Services Contract.

The completed LOI, LOA, or an executed Network Provider 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 Dental Services 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 (1) page LOI and LOA formats, a Respondent must collect the additional provider and services information (numbered items 1 though 12), for each LOI and LOA, 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 DENTAL SERVICES MEMBERS").

LETTER OF INTENT TO ENTER INTO CONTRACT NEGOTIATIONS WITH
[The Respondent]
FOR PROVISION OF SERVICES TO HHSC DENTAL SERVICES 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 dental services to [Medicaid/CHIP/Medicaid and CHIP] 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 [Medicaid/CHIP/Medicaid and CHIP] members.

[Respondent's name] is proposing to participate in the Dental Services Program. The provider signing below is willing to enter into contract negotiations with [Respondent's name], for the provision of dental services to [Medicaid/CHIP/Medicaid and CHIP] 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 Dental Services contract 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 Dental Services for the Medicaid and CHIP Programs. 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 DENTAL SERVICES 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 dental services to [Medicaid/CHIP/Medicaid and CHIP] Members. Signing this Letter of Agreement obligates the provider to sign a contract with [Respondent's name] for the provision of services to [Medicaid/CHIP/Medicaid and CHIP] Members.

[Respondent's name] is proposing to participate in the Dental Services Program. The provider signing below agrees to contract with [Respondent's name], for the provision of dental services to [Medicaid/CHIP/Medicaid and CHIP] members enrolled with [Respondent's name] as indicated below.

This provider agrees to sign a contract with [Respondent's name] if [Respondent's name] is awarded a Dental Services contract.

NOTICE TO PROVIDERS:
This Letter of Agreement may be used by HHSC in its bid evaluation and contract award process for the RFP for Dental Services for the Medicaid and CHIP Programs. 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 dentist, 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 DENTAL PROGRAM 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. General Dentist, Orthodontist, Periodontist, etc.)

____

9. AREAS OF PROVIDER SPECIALTY, IF ANY

____

10. LANGUAGES SPOKEN BY THE PROVIDER (OTHER THAN ENGLISH)

____

11. NAME OF HOSPITAL(S) WHERE DENTIST HAS ADMITTING PRIVILEGES

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