

# COMMUNITY CARE ASSOCIATES INC.

P.O. Box 44230  
DETROIT, MICHIGAN 48244  
TELEPHONE 313-961-3100 FAX 313-961-3116

## **PHYSICIAN/PROVIDER AGREEMENT TO PARTICIPATE IN CCA-I** **Please complete the following:**

Provider Name \_\_\_\_\_

Physician's Name \_\_\_\_\_ MD,DO,DPM (Please circle)

Specialty 1 \_\_\_\_\_ Specialty 2 \_\_\_\_\_

MI License # \_\_\_\_\_ Date of license \_\_\_\_\_

Tax ID License \_\_\_\_\_ DEA License \_\_\_\_\_

NPI # \_\_\_\_\_ NABP #: \_\_\_\_\_

Office Address 1 \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Telephone # \_\_\_\_\_ Fax # \_\_\_\_\_

Office Address 2 \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Telephone # \_\_\_\_\_ Fax # \_\_\_\_\_

### **(FOR ADDITIONAL SITES, PLEASE INDICATE ON THE BACK OF THIS SHEET)**

Office Contact Person \_\_\_\_\_ Title \_\_\_\_\_

E-mail Address \_\_\_\_\_ Board Certified \_\_\_\_\_

Board Certification Specialty Area (s) \_\_\_\_\_

Certification Dates \_\_\_\_\_

Hospital Affiliations \_\_\_\_\_

I, \_\_\_\_\_, do hereby agree to care for Wayne County HealthChoice members enrolled in Community Care Associates, Inc., to abide by the rules and regulations governing Wayne County's HealthChoice Program and accept fees as payment in full.

**REIMBURSEMENT----- 100 + 10 % OF THE MEDICAID FEE SCREEN \$20.00 COPAY  
UNLESS THE ANNUAL**

**Termination by either party requires a written 30-day notice.**

**Physician/Provider**

**I  
I  
I**

**By the President of CCA Inc.**

**Signed this \_\_\_\_\_ day of 20\_\_**

**Signed this \_\_\_\_\_ day of 20\_\_**