COMMUNITY CARE ASSOCIATES INC.

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

PHYSICIAN/PROVIDER/MENTAL HEALTH 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—MEDICAID FEE SCREEN + 10%
ALL MENTAL HEALTH SERVICES MUST BE PRIOR-AUTHORIZED AND HAVE A $20.00 CO-PAY

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

Physician/Provider **By the President of CCA Inc.**

Signed this _____day of 20__ **Signed this _____day of 20__**