COMMUNITY CARE ASSOCIATES INC.

P.O. BOX 44230 DETROIT, MI 48244
TELEPHONE 313-961-3100 FAX 313-961-3116

__PHYSICIAN/PROVIDER AGREEMENT TO PARTIPATE IN CCA, INC.__

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 # ____________________________

Office Address 1 ______________________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 ____

I, ________________________________, do hereby agree to care for Wayne County's Health Choice members enrolled in Community Care Associates, nc., to abide by the rules and regulations governing Wayne County's Health Choice program and accept fees as payment in full.

Termination by either party requires a written 60 day notice.

Reimbursement: Medicaid Fee Screen

Provider	**President of CCA Inc.**
Signed this _____________day of 201_	**Signed this _____________day of 201_**