COUNTYCARE LETTER OF AGREEMENT ("LOA")
Cook County Health and Hospital Systems/CountyCare

This **COUNTYCARE LETTER OF AGREEMENT** between the County of Cook ("County"), through its Cook County Health and Hospitals System ("CCHHS"), and INSERT PROVIDER NAME (referred to herein individually as a "Party" or, collectively, as the "Parties").

WHEREAS, CCHHS has entered into an arrangement with the Department of Healthcare and Family Services of the State of Illinois ("HFS" or "Department") for its Medicaid health plan, CountyCare, to arrange for the delivery of health care services to the expanded population of Medicaid eligible individuals as a County Managed Care Community Network ("MCCN");

NOW, THEREFORE, in consideration of these premises and of the mutual covenants and promises contained herein, the Parties hereby agree as follows:

Parties agree to accept the rate indicated below as payment from CountyCare for procedures provided to INSERT PATIENT NAME during the time period indicated below.

PATIENT NAME:	**RIN #:**
ACCEPTING PROVIDER:	**PROVIDER TAX ID #:**
NPI:	**PERIOD OF AGREEMENT:**
DOB	**AUTHORIZATION #:**
REIMBURSMENT RATE: For Covered Services rendered to a Covered Person, and billed under the Provider's tax identification number ("TIN"), CCHHS shall pay Provider the lesser of: (i) Provider's Allowable Charges; or (ii) one hundred percent (100%) of the State Medicaid fee schedule in effect on the date of service.	

Both parties agree that the terms and rates set forth in this Letter of Agreement are confidential and will not be shared with any other third party. Charges associated with the care of this patient shall be compiled with the same methodology as all other patients treated by the above named entities.

Parties agree and understand that the terms of this LOA in and of itself do not guarantee payment for services. Providers must meet administrative requirements (e.g. member eligibility, covered services, claim submission timeliness, third-party insurance, etc.) before CountyCare provides reimbursement for services.

PARTIES agree to indemnify, defend and hold harmless the other, its agents and employees from and against any and all liability or expense, including defense costs and legal fees, incurred in connection with claims for damages of any nature, including but not limited to bodily injury, property damage or other damages arising from the performance or failure to perform its obligation under this Agreement, unless it is determined that the liability was the direct consequence of negligence or willful misconduct on the part of the party, its agents or employees.

All claims shall be sent to the following address:

CountyCare Health Plan
P.O. Box 211592
Eagan, MN 55121-2892
Payor ID: 06541

This agreement reflects the entire understanding, and supersedes all prior agreements, between the parties.

For: INSERT PROVIDER NAME

Printed Name: _____

Title: _____

Date: _____

Signature: _____

For: Cook County Health and Hospital System

Printed Name: Aaron Galeener

Title: CountyCare Director of Finance

Date: _____

Signature: _____