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.

HOME CARE VISITS MUST BE AUTHORIZED, FOLLOW AN INPATIENT ADMISSION AND REQUIRE A $20.00 CO-PAY.

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

Physician/Provider

Signed this _____ day of 20__

By the President of CCA Inc.

Signed this _____ day of 20__