Dear Provider:

Carolina Complete Health is excited to be selected as a regional Provider Led Entity serving regions 3, 4, and 5! Participating with Carolina Complete Health presents a unique opportunity for Medicaid providers in North Carolina to shape the delivery of healthcare services in an evidence-based, outcomes-driven manner. Your clinical experience and your knowledge of your patient population will be brought to bear in creating a stable, sustainable, and compassionate method to achieve a healthier North Carolina and we invite you to become a participating provider with our health plan. Attached is a sample contract for your information and review.

To expedite your participation with Carolina Complete Health, please visit our website at https://network.carolinacompletehealth.com to request a contract; a contract will be prepared to specifically include your legal entity name and the appropriate compensation exhibit(s) for your specialty and/or the services you provide. Once you have requested a contract via the website, a member of our Network team will reach out to you directly to get the process started.

If you prefer to call us to request a contract, please contact us at 919-719-4161 and a member of our Network team will work with you to get the process started. Once you receive the contract and any related documents, please note these handy tips to assist in speedier processing:

1. Fully complete the "Notices" information requested in the contract (Section 8.12).
2. Execute (by signing) the Participating Provider Agreement.
3. Complete Schedule C.
4. If you are an Indian Health Care Provider, please also sign the Attachment A: Medicaid MEDICAID MANAGED CARE ADDENDUM FOR INDIAN HEALTH CARE PROVIDERS.
5. Complete the applicable provider applications;
    a. Complete the "CCH - Provider Roster Template Medicaid" document for your practice/entity noting required fields.

    OR

    b. Complete the Provider Data Form in its entirety. If your practice has multiple locations, please copy and complete the information for each location as noted in document.

    AND

    c. If you are a Hospital or Facility provider, please complete the Hospital/Facility Application and any Addendum sent to you by your Network contact, in its entirety.
6. Include a signed W-9 form.
7. Once completed, please scan and email the completed documents back to your Network contact as instructed by that party, or mail the materials to**:**

Via Mail: Carolina Complete Health, Inc.
ATTN: Network Relations
4309 Emperor Boulevard, Suite 430
Durham, NC 27703

We look forward to a long-standing partnership and collaborating with you to improve the health of our community, one individual at a time.

Sincerely,
Network Relations