ACCESS
HEALTHCARE PHYSICIANS, LLC.

Date:

Dear Representative: **TIME SENSITIVE RESPONSE NEEDED**

Please accept this Letter of Intent as our notice that we, Access Health Care Physicians, LLC, TIN: 451444883, NPI: 1245529742, Taxonomy 193200000X (Multispecialty) are adding the below provider to our group for all lines of business for our practice as to assure consistent patient care coverage.

LAST NAME	FIRST NAME	SUFFIX	NPI	CAQH#	EFFECTIVE DATE

TAXONOMY PRIMARY	PRIMARY SPECIALTY

Credentialing / Corporate Address					
Address	**City**	**State**	**Zip**	**Phone**	**Fax**
14690 SPRING HILL DRIVE #101	SPRING HILL	FL	34609-8102	352-799-0046	352-799-0042

Pay to / Remittance Address:					
Address	**City**	**State**	**Zip**	**Phone**	**Fax**
PO BOX 919469	ORLANDO	FL	32891-9469	727-823-2188	727-828-0723

PRACTICE LOCATIONS	
Primary Address:	**Secondary Address:**

If you have any questions, please do not hesitate to contact credentialing at 352-799-0046 or via email to credentialing@accesshealthcarellc.net.

Please confirm receipt of this notice and estimated time of completion. Upon completion of the contracting and credentialing for this provider, please provide:

1. Effective Date
2. Insurance Provider ID#
3. Confirmation of Lines of Business
4. Next credentialing date

Sincerely,
Access Credentialing Department

ATTACHMENT D

GROUP SIGNATURE PAGE

The following Physician signatures are for Access Health Care Physicians LLC tax identification number 451444883. By signing below the Physicians agree to abide by the terms and conditions of the Agreement.

Signature	Print Name	Date
Signature	Print Name	Date
Signature	Print Name	Date
Signature	Print Name	Date
Signature	Print Name	Date
Signature	Print Name	Date
Signature	Print Name	Date
Signature	Print Name	Date
Signature	Print Name	Date
Signature	Print Name	Date

Provider initials _____