Encounter Rate through MCOs Participation Form for RHCs

Instructions :
1. Complete this form and return to HCA by 5pm on September 30th, 2017 2. Indicate your clinic's name and the NPI associated with your RHC Taxonomy 3. Clearly mark each MCO you are currently contracted with 4. Read the form in full and sign indicating your choice to opt-in 5. Submit this form by emailing fqhcrhc@hca.wa.gov or via fax at (360) 753-9152

Rural Health Clinic Name_____

RHC NPI _____

In order to ensure a timely transition to encounter at time of service, we request that you indicate which MCOs you are contracted with. Please mark all that apply with an X:

This RHC is contracted with the following MCOs:	
Amerigroup	
Community Health Plan of Washington	
Coordinated Care	
Molina Healthcare	
United Health Care	

By signing this form I understand that I am choosing the payment option that will allow my clinic to receive its full encounter rate from MCOs my clinic is contracted with. I also agree to receive my encounter rate through MCOs for the entire calendar year of 2018 with the option to remove my clinic in the following calendar year. I acknowledge that this clinic will no longer receive monthly enhancement payments and will no longer need to reconcile for calendar years in which this clinic is enrolled in this payment option.

Name:_____ **Signature**:_____

Title: _____ **Date:** _____