Florida Medicaid Provider Enrollment Application
For A Treating Provider Contracted To A Medicaid Managed Care Entity

Provider Name				
DBA *(Leave blank, if same as provider name listed above. Do not enter your employer's name here.)*				
Physical Street Address (no P O Boxes)				
Building, Suite (if applicable)				
City			**State**	**Zip**
County Name		**Telephone Number**		
		( )		
Business E-mail address (optional)				
Tax ID Number (enter either your *SSN* or *FEIN)*		**National Provider ID** (NPI)		
Professional License *(if applicable)*	**Facility License Number** *(if applicable)*	**CLIA License Number** *(if applicable)*		
Provider Type Code	**Practice Type Code**	**Category of Service**	**Ownership Code**	**Specialty Code**

Note: The various codes required to complete this section may be found at http://floridamedicaid.acs-inc.com in the appendices of the "Guide for Completing a Florida Medicaid Provider Enrollment Application".

APPLICANT CERTIFICATION

"For the purposes of establishing eligibility to receive direct or indirect payment for services rendered to recipients of the Florida Medicaid Program, I understand that, under Section 409.920(2)(f), Florida Statutes, the filing of materially incomplete or false information with this enrollment request is a third degree felony and is sufficient cause for termination from the Florida Medicaid Program. I further understand that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws. I understand that I am responsible for the information presented on this application and that the information is true, accurate, and complete. Furthermore, I agree to abide by the provisions of this provider agreement effective from the date that the services or goods were provided, pursuant to Section 409.907(11), Florida Statutes."

I understand that it is my responsibility to notify Medicaid's fiscal agent of any change to the information on this application, including but not limited to, a change of address or group affiliation."

Legibly Print Name of Applicant or Authorized Signer	Title	Signature	Date

MANAGED CARE PLAN APPROVAL

"The applicant listed above has been certified as meeting all Medicaid enrollment requirements as listed in the Florida Medicaid Provider General Handbook as well as the Coverage and Limitations Handbook that governs the specific program for which they will provide services and is authorized to provide services under the Medicaid enrolled HMO or PSN Network listed below."

Name of Managed Care Plan			Managed Care Plan's Medicaid ID
Legibly Print Name of Managed Care Representative	**Title**	**Signature**	**Date**

For assistance, please call ACS Provider Enrollment at 1-800-377-8216.

Important Instructions

- Only persons or entities that render medical, medical-related or waiver-related services to Medicaid recipients through a Medicaid contracted managed care entity (HMP/PSN) may complete this form.
- This form ***may not be used*** to apply as a fee-for-service provider. If you plan to submit claims directly to Medicaid for fee-for-service reimbursement, you must submit the full *Florida Medicaid Provider Enrollment Application,* available at http://floridamedicaid.acs-inc.com .
- Please type or print in blue or black ink. Do not use red ink.
- Original signatures are required. No copies, stamps or facsimiles are accepted.

NOTE: The applicant must forward the completed application to the managed care plan they are contracting with to obtain an approval signature from an authorized representative of the managed care plan. This must be done before the application may be submitted to ACS State Healthcare for processing. Applications received without the managed care plan's approval signature will be returned to the applicant.

Verify both the applicant and a representative of the managed care plan have signed the application. Make a copy for your records and mail the original to:

For Regular Mail:

ACS State Healthcare
Provider Enrollment
P.O. Box 7070
Tallahassee, FL 32314-7070

For Overnight or Express Delivery:

ACS State Healthcare
Provider Enrollment
2308 Killearn Center Blvd STE 100
Tallahassee, FL 32309

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