Provider Name: _____ **Tax ID:** _____

Florida Medicaid
Provider Enrollment Application
Out-Of-State Fee-For-Service Delivery

Fields marked with an asterisk (*) are required.
Fields marked with a carat (^), complete as applicable.

REASON FOR SUBMISSION OF THIS APPLICATION* *(check one)*

- ❑ An individual covered under the Florida Medicaid program experienced an emergency arising from an accident or illness while traveling outside of Florida.
- ❑ The health of an individual covered under the Florida Medicaid program will be endangered if care and services are postponed until returning to Florida.
- ❑ A non-Title-IV-E foster or adoption subsidy child covered by the Florida Medicaid Program is living out-of-state.
- ❑ Florida Medicaid prior authorized medical services or necessary supplementary resources for delivery in a state other than Florida.

NOTE: The following out-of-state providers must enroll using the online Florida Medicaid Provider Enrollment Application located at www.mymedicaid-florida.com.

- *Durable medical equipment and supplies entities enrolling as Medicare Crossover-Only providers.*
- *Fully licensed physicians in Florida that interpret diagnostic testing results from an out-of-state location through telecommunications and information technology.*
- *Independent laboratories certified under the Clinical Laboratory Improvement Amendments.*
- *Medical supply and durable medical equipment (DME) providers and pharmacies that supply items that are not otherwise available from providers located within Florida. (Requires prior approval to enroll from the State of Florida, Agency for Health Care Administration.)*

ENROLLMENT TYPE*

Taxonomies and Specialties by Provider Type can be obtained from the Medicaid Taxonomy Master List located on the Provider Enrollment Forms page at www.mymedicaid-florida.com.

Application Type*		First Date of Service* *(mm/dd/yyyy)*
❑ Sole Proprietor	❑ Facility of Other Business Entity	
Provider Type*	**Specialty Type***	**Taxonomy***
Ownership Type*		
❑ Private For-Profit	❑ Private Not-for-Profit	❑ Publicly Traded

IDENTIFYING INFORMATION*

Business or Last Name* *Note: The name on this application must match exactly the name as registered with the IRS, Medicare, the National Plan and Provider Enumeration System, and on any professional or facility license.*		
First Name^	**Middle Initial^**	**Jr., Sr., etc.^**
Doing Business As (D/B/A)^		

Tax ID Type*	Tax ID*	Medicaid ID* *(for state of operation)*	Medicare ID^
❑ SSN ❑ FEIN			
NPI Type*	**NPI***	**Taxonomy***	**ZIP+4***
❑ Ind. ❑ Org.			
License/Permit*	**Licensing State***	**Eff. Date*** *(mm/dd/yyyy)*	**Exp. Date*** *(mm/dd/yyyy)*

Florida Medicaid uses the NPI, Taxonomy, and service location ZIP +4 submitted in electronic or paper claims to map the provider to their Florida Medicaid provider ID. Providers required to enroll with an NPI should include their NPI, Taxonomy appropriate for their specialty, service location ZIP+4, and service location address on their claim submissions to support successful processing.

Provider Name: _____ **Tax ID:** _____

ADDRESSES*

Service Address*

Street Address Line 1*			
Street Address Line 2^			
City*	State*	ZIP +4*	County*
Telephone Number*	Fax Number^	E-mail Address*	

Payment Address*

❑ Same as Service Address

Address Line 1*		
Address Line 2^		
City*	State*	ZIP +4*
Telephone Number* *(with Area Code)*	Fax Number^	
E-mail Address*		

General Correspondence*

❑ Same as Service Address ❑ Same as Payment Address

Address Line 1*		
Address Line 2^		
City*	State*	ZIP +4*
Telephone Number* *(with Area Code)*	Fax Number^	
E-mail Address*		

Home or Corporate Office Address*

❑ Same as Service Address ❑ Same as Payment Address ❑ Same as Correspondence Address

Address Line 1*		
Address Line 2^		
City*	State*	ZIP +4*
Telephone Number* *(with Area Code)*	Fax Number^	
E-mail Address*		

OWNERSHIP INTEREST AND MANAGING CONTROL INFORMATION*

Organizations^

This section is to be completed with information about any organization that has direct or indirect ownership of, a partnership interest in, and/or managing control of the provider. If there is more than one organization, copy and complete this section for each.

Legal Business Name* *(as reported to the Internal Revenue Service)*		
Doing Business As (DBA)		
Address Line 1*		
Address Line 2^		
City*	State*	ZIP+4*

Tax ID Type*	Tax ID*
FEIN	

Percentage Control*

❒ Owner of 5% or greater direct ownership or controlling interest

❒ Owner of 5% or greater indirect ownership or controlling interest

Percentage of direct or indirect ownership*	Effective date of ownership or control/interest* *(mm/dd/yyyy)*

Individuals^

This section is to be completed with information about any individual who has direct or indirect ownership of, a partnership interest in, and/or managing control of the provider identified in the provider. If there is more than one individual, copy and complete this section for each. All individuals must be fingerprinted. Information on background screening can be found under Enrollment at www.mymedicaid-florida.com.

First Name*	Middle Initial^	Last Name*	Jr. Sr., etc.^

Address Line 1*
Address Line 2^

City*	State*	ZIP+4*

Social Security Number*	Date of Birth*	Medicare ID^ *(Individuals enrolled in Medicare with current background screenings on file do not require fingerprinting.)*

Percentage Control* (check all that apply)

❒ Owner of 5% or greater direct ownership or controlling interest

❒ Owner of 5% or greater indirect ownership or controlling interest

❒ Officer

❒ Director (includes Board of Directors)

❒ W-2 Managing Employee

❒ Contracted Managing Employee

Percentage of direct or indirect ownership*	Effective date of ownership or control/interest* *(mm/dd/yyyy)*

Provider Name: _____ **Tax ID:** _____

CONTACTS*

General *

First Name*	Middle Initial^	Last Name*	Jr. Sr., etc.^

Telephone Number*	Fax Number *(if applicable)*	E-mail Address*

Address Line 1* *(Street Name and Number)*

Address Line 2^ *(Suite, Room, etc.)*

City*	State*	ZIP +4*

Medical Records Custodian*

❑ Same as Contact Person

(Skip to Financial Records Custodian if checked)

First Name*	Middle Initial^	Last Name*	Jr. Sr., etc.^

Telephone Number*	Fax Number *(if applicable)*	E-mail Address*

Address Line 1* *(Street Name and Number)*

Address Line 2^ *(Suite, Room, etc.)*

City*	State*	ZIP +4*

Financial Records Custodian*

❑ Same as Contact Person ❑ Same as Medical Records Custodian

(Skip to Certification Statement if either is checked)

First Name*	Middle Initial^	Last Name*	Jr. Sr., etc.^

Telephone Number*	Fax Number *(if applicable)*	E-mail Address*

Address Line 1* *(Street Name and Number)*

Address Line 2^ *(Suite, Room, etc.)*

City*	State*	ZIP +4*

Provider Name: _____ **Tax ID:** _____

ELECTRONIC FUNDS TRANSFER (EFT) AGREEMENT*

Provider Information

Provider Name*

Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)*	National Provider Identifier (NPI)^

Financial Institution Information

Financial Institution Name*		
Financial Institution Routing Number*		
Type of Account at Financial Institution*		
❑ Checking	❑ Savings	❑ Lock Box
Provider's Account Number with Financial Institution*		
Account Number Linkage to Provider Identifier* (*Must match preference submitted on ERA*)		
❑ Provider Tax Identification (TIN)	❑ National Provider Identifier (NPI)	
NOTE: This information is being collected in the event Florida Medicaid changes EFT linkage (which is currently done by Medicaid Provider Identification Number.)		

Submission Information

NOTE: Authorized Signature - The Individual (s) listed below are authorized by the provider or its agent to initiate, modify, or terminate an EFT enrollment.

Authorized Signature*	
Printed Name of Person Submitting Enrollment*	
Printed Title of Person Submitting Enrollment*	Submission Date*

Complete only if more than one authorized signer.

Authorized Signature*	
Printed Name of Person Submitting Enrollment*	
Printed Title of Person Submitting Enrollment*	Submission Date*

Provider Name: _____ **Tax ID:** _____

CERTIFICATION STATEMENT*

I, _____, certify that I am the provider identified above, or am duly authorized to act on behalf of the provider, and do hereby submit this application for the sole purpose of enrolling in the Florida Medicaid program. I certify that any claims for services submitted to the State of Florida, Agency for Health Care Administration (Agency) meet the condition of the reason for submission as indicated in this document. I understand that this is a voluntary agreement between the Agency and the provider, in which the provider agrees to furnish services or goods to Medicaid recipients in compliance with all state and federal laws and regulations governing the Medicaid program.

I understand that I am responsible for the information disclosed on this document and certify that the information is true, accurate, and complete.

I understand that the filing of materially incomplete or false information with this certification document is a felony and is sufficient cause for denial of enrollment or termination from the Florida Medicaid program, per § 409.920, f.s.

I understand that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

Furthermore, I understand that it is my responsibility to notify the Agency of any changes to the information disclosed in this document."

_____ _____

Signature of Authorized Representative* Date*

_____ _____

Printed Name of Authorized Representative* Title*

BUILDING THE APPLICATION PACKET

The applicant must submit the following forms and documentation with this application:

- Institutional or Non-Institutional Florida Medicaid Provider Agreement, as appropriate.
- Each person with signing privileges on the depository account should sign this form. If the account has more than four signers, attach copies of page 5 as needed.
- A voided check or letter on a bank letterhead to certify the routing and account numbers provided in the EFT section.
- Copy of facility or professional license, as appropriate.
- Completed claim form with documentation supporting the reason for submission, as indicated in this application.

The Provider Agreement form can be obtained from the Provider Enrollment Forms page at www.mymedicaid-florida.com.

SUBMITTING THE APPLICATION

Mail the completed application and all required attachments in a single packet to:

Medicaid Provider Enrollment
Attn: Out-of-State Unit
P.O. Box 7070
Tallahassee, FL 32314-7070