

Group Membership Authorization

Check one:

- Add a new Florida Medicaid group link (requires the treating provider's signature), or
- End an existing Florida Medicaid Group Link (may be signed by the treating provider or the group)

SECTION 1: IDENTIFYING INFORMATION

A. Enter the individual provider's information

First Name	Middle Initial	Last Name	Jr. Sr., etc.
Professional License		Florida Medicaid provider ID (or Application Tracking Number)	

B. Enter the group provider's information

First Name	Middle Initial	Business or Last Name	Jr. Sr., etc.
Doing Business As (D/B/A)			
Tax ID		Florida Medicaid Provider ID (if enrolled)	
E-mail Address <i>(used to resolve questions with this form)</i>			

SECTION 2: Service Locations and Effective Date

Enter the group's Florida Medicaid ID and corresponding service address.

Enter the Effective Date when adding a new group link.

NOTE: if the date the provider joined the group is earlier than the date the provider or the group were effective with Florida Medicaid, the group link will be effective with the later date.

Enter the End Date if terminating an existing group link.

Group's Florida Medicaid ID (if enrolled)	Effective Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
Service Location Street Address Line 1 <i>(Street Name and Number – NOT a P.O. Box)</i>		
City/Town	State	ZIP Code + 4

Florida Medicaid Provider ID: _____
or, Application Tracking Number (ATN)

Group's Florida Medicaid ID (if enrolled)	Effective Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
Service Location Street Address Line 1 (Street Name and Number – NOT a P.O. Box)		
Service Location Street Address Line 2 (Suite, Room, etc.)		
City/Town	State	ZIP Code +4
Group's Florida Medicaid ID (if enrolled)	Effective Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
Service Location Street Address Line 1 (Street Name and Number – NOT a P.O. Box)		
Service Location Street Address Line 2 (Suite, Room, etc.)		
City/Town	State	ZIP Code +4
Group's Florida Medicaid ID (if enrolled)	Effective Date (mm/dd/yyyy)	End Date (mm/dd/yyyy)
Service Location Street Address Line 1 (Street Name and Number – NOT a P.O. Box)		
Service Location Street Address Line 2 (Suite, Room, etc.)		
Service Location Street Address Line 1 (Street Name and Number – NOT a P.O. Box)		
City/Town	State	ZIP Code + 4
SECTION 3: Certification Statement		
<p><i>"I authorized the group providers listed above to submit claims for services performed by myself. I understand that, by making this request, all disbursements made for services performed by myself under these groups will be made directly to the groups on my behalf. I further understand these payments will be reported to the Internal Revenue Service under the group's tax id, not under my own"</i></p>		
Signature of Person Submitting Authorization		
Printed Name of Person Submitting Authorization		Submission Date

