For Fiscal Agent Use: _____

Florida Medicaid Out-of-State Provider Enrollment Application

- **Please type or print in blue or black ink. Do not use red ink.**
- **If you have any questions, there is an FAQ list on the fiscal agent's website (listed at the bottom of this page) or call EDS Provider Enrollment Services at 1-800-289-7799, Option 4.**

Name of Business or Individual: _____

Doing Business As (D/B/A): _____

Physical Street Address: _____
(Required)

Building, Suite Number: _____
(or PO Box if applicable)

City: _____

State: _____

ZIP+4: _____ - _____

Telephone Number: (____) _____
Area Code

Fax Number: (____) _____
Area Code

Contact Person: _____

Tax Identification Number: **SSN** _____ - ____ - _____
or
FEIN ____ - _____

License Information: **Professional License Number** _____
or
Facility License _____

Dates of Service: ____ / ____ / ____ **through** ____ / ____ / ____

Certification:

"For the purposes of receiving reimbursement for services provided to eligible 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 this application is approved, pursuant to Section 409.907(9),(a), Florida Statutes.

_____ _____
Signature of Provider or Authorized Representative **Date**

_____ _____
Name of Provider or Authorized representative **Title**
(Please Type or Print Legibly)

- **Sign and submit with this application the appropriate Florida Medicaid Provider Agreement** (See attached cover letter for instructions. Provider agreements are available from the fiscal agent's web site listed at the bottom of this page).
- **Keep a copy of the enrollment application and all attachments for your files.**
- **Mail the completed application packet to:**

For Regular Mail:	**For Overnight or Express Delivery:**
EDS Provider Enrollment P.O. Box 7070 Tallahassee, FL 32314-7070	EDS Provider Enrollment 2671 Executive Center Circle, Suite 100 Tallahassee, FL 32301

Visit the fiscal agent web site for electronic versions of all enrollment forms: www.mymedicaid-florida.com.