**For Fiscal Agent Use:** _____

# Florida Medicaid Provider Enrollment Application - Clearinghouse Use Only

- **Any person or entity that operates as a clearinghouse to Medicaid providers must enroll as a Medicaid provider by completing this form along with a *Florida Medicaid Non-Institutional Provider Agreement*.**
- **Any person or entity that operates as a billing agent to Medicaid providers may not use this form. Billing Agents must complete the full *Florida Medicaid Provider Enrollment Application*.**
- **Please type or print in blue or black ink. Do not use red ink.**
- **If you have any questions, please call EDS Provider Enrollment 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:** _____

**Telephone Number:** (  ) _____ **County Name:** _____
Area Code

**Tax Identification Number:** _____
*Enter either the SSN or FEIN by which the IRS knows you. Attach a legible copy of your SSN card, IRS Form SS-4, 1072, or W-9 as proof of your tax id.*

**Type of Ownership:** _____
*Use one of the following: **1** - County Owned, **2** - State Owned, **3** - City Owned, **4** - Church Owned, **5** - Privately Owned, for-Profit, **6** - Privately Owned, Not-for-Profit, **7** - Publicly Traded Corporation, or **8** - Other.*

**Owner(s) and Operator(s):** Any future correspondence regarding the provider file must contain a signature of one of the persons identified below. (Attach additional sheets as necessary.)

| Name | SSN | Title | Relationship |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

*NOTE: Select one or more from the following list when indicating the relationship of the individuals listed above to the business entity: Owner, Officer, Director, Partner, Manager, Shareholder, Sub-Contractor, Medical Records Custodian, or Financial Records Custodian.*

*"For the purposes of establishing eligibility to provide clearinghouse services to providers 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.*

*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, ownership, officers, directors, tax identification number, or clearinghouse status."*

_____ _____
Signature of Provider or Authorized Agent/Registered Agent Date

_____ _____
Name of Provider or Authorized Agent/Registered Agent Title
*(Please Type or Print Legibly)*

- **Sign and submit with the application a Florida Medicaid Non-Institutional Provider Agreement** (available from the fiscal agent's web site listed at the bottom of this page).
- **Keep a copy of the enrollment application for your files.**
- **Mail the completed application and provider agreement, with original signatures, to the address as listed below.**

| **For Regular Mail:** | **For Overnight or Express Delivery:** |
|---|---|
| EDS<br>Provider Enrollment<br>P.O. Box 7070<br>Tallahassee, FL 32314-7070 | EDS<br>Provider Enrollment<br>2671 Executive Center Circle, Suite 100<br>Tallahassee, FL 32303 |

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