For Fiscal Agent Use: _____

Managed Care Treating Provider Registration

Providers who are not already enrolled with the Florida Medicaid program, and who perform services for Florida Medicaid eligible recipients under a Medicaid capitated managed care organization (MCO), may submit this form to obtain a Florida Medicaid provider ID. The provider ID may then be used to submit encounter data for the services rendered under the MCO. The provider may also be available as an option for assignments in the choice counseling process.

- **Applicants who do not sign this form will not be available as an option for assignments in the choice counseling process.** An MCO may submit the form on their behalf and a provider ID will be assigned solely for the submission of encounter data.
- **This form may not be used to apply as a fee-for-service provider.** If the applicant plans to submit claims directly to Florida Medicaid for fee-for-service reimbursement, they must submit the full Florida Medicaid Provider Enrollment Application, available at http://mymedicaid-florida.com.

1. Provider Name

Enter the applicant's name and, if applicable, a Doing Business As (D/B/A) designation.

Last Name or Business Name: _____

First Name: _____

Middle Name or Initial: _____

Doing Business As: _____
(Optional)

2. Tax Information

Check the appropriate box to indicate a Social Security Number (SSN) or Federal Employer Identification Number (FEIN) and list the nine (9) digit number.

❑ **Social Security Number** ❑ **Federal Employer Identifier Number** _____

3. Address Information

NOTE: The Service Location Address must be a physical location, not a Post Office box or mail service center.

Service Location Address: _____

Building, Suite Number: _____

City: _____ **State:** _____ **ZIP:** _____

County: _____

Telephone Number: ( )
Area Code

4. Service Type Information

Enter the appropriate provider type and specialty from the *"Guide for Completing a Florida Medicaid Provider Enrollment Application"* located at http://mymedicaid-florida.com for the services you plan to provide.

NOTE: If the applicant's provider type is not one of the standard Florida Medicaid provider types as listed in the "Guide for Completing a Florida Medicaid Provider Enrollment Application", enter provider type "97", Managed Care Treating Provider, Non-Medicaid, and choose one of the following codes to populate the specialty code field.:

800 – Acupuncturist
801 – Nutritionist
802 – Independent Diagnostic Testing Facility
803 – Other

Provider Type: _____ **Specialty Type:** _____

5. Provider Identifier Information

Enter the applicant's NPI, taxonomy, professional or facility license, pharmacy permit, or CLIA Certificate, if applicable.

NPI: _____
(if required by NPI rule)

Taxonomy: _____
(required)

License/Permit: _____
(if required to practice the services indicated in # 4 above.)

CLIA Certificate: _____
(if required to practice the services indicated in # 4 above.)

For Fiscal Agent Use: _____

APPLICANT ATTESTATION

"By signing this registration, I am requesting registration in Florida Medicaid for the sole purpose of linking as a treating provider to the MCO identified on this registration. I understand that this registration does not require me to accept Florida Medicaid recipients, except as assigned under the MCO; it does not entitle me to submit fee-for-service claims to Florida Medicaid; or, to be directly reimbursed by Florida Medicaid for services rendered. I further understand it is my responsibility to notify Florida Medicaid of any future changes to the information on this application, including but not limited to, changes of address or plan affiliation."

Type or Print Name of Signatory	*Title*	*Signature*	*Date*

6. MCO Information

This registration will be returned to the address below if there are deficiencies.
If the provider is to be linked to more than one of the MCO's Medicaid IDs, list the additional IDs at the bottom of this page.

Name of MCO _____ **Medicaid ID** _____

Home/Corp Office Address: _____

Building, Suite Number: _____

City: _____ **State:** _____ **ZIP:** _____

County: _____

Telephone Number: ( ) _____
Area Code

MCO ATTESTATION

"On behalf of the Medicaid MCO named in this registration, I attest that 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 managed care organization listed on this registration.

Furthermore, if this registration was submitted without the applicant's signature, I attest that a good-faith effort has been made to register this treating provider for a Florida Medicaid provider ID and that said provider refused to complete and submit the Managed Care Treating Provider Registration form."

Print Name of Managed Care Plan's Signatory	*Title*	*Signature*	*Date*

Make a copy for your records and mail original to:

For Regular Mail:

EDS PROVIDER ENROLLMENT
PO BOX 7070
TALLAHASSEE, FL 32314-7070

For Overnight or Express Delivery:

EDS PROVIDER ENROLLMENT
2671 W EXECUTIVE CENTER CIR STE 100
TALLAHASSEE, FL 32301-5020