

** use proper capitalization, * do not print/scan the form*

AHCA user: _____ Password: _____

\$175.00

ADDRESS Change: Effective Date: _____

** Please save the document in your computer, using Adobe Reader type the info, and then email to us*

AHCA:

Agency Name: _____

License #: _____ NPI: _____ MC #: _____ MA #: _____
(Medicare Provider #) (Medicaid Provider #)

Issue date: _____ Exp Date: _____
(License)

New Address: _____ City: _____

Zip Code new (*include 4 last digits*): _____ + _____ County: _____

New Phone: _____ New fax: _____

Tax ID: _____ email _____ Web site: _____

Contact Person/Title: _____ % ownership: _____ Date: _____

SS #: _____ DOB: _____ State Born: _____ Country Born: _____

Add when to sent to AHCA (21 days in advance): Copy of Lease, Zoning Letter, Insurance certificate, \$ 25.00 check

(Do not fax to us)

Administrator Name: _____

After AHCA approval:

Incorporation Date: _____ Medicare # issue date: _____

Accreditation Body: _____ Date: _____ Expiration: _____

CLIA #: _____ DON: _____

Bank Name: _____ Bank Ph: _____

Bank Contact person: _____

Routing: _____ Account: _____

Bank Address: _____

Click bellow to email the form:

or fax to (305) 819-4064

Agency Glucomer (brand/model): _____

Test strip (brand/model): _____

Lancets brand/model: _____

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