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| **RESPONDENT’S NAME:**       |

1. **IDENTIFICATION OF PLAN TYPE**

I hereby certify that my company is submitting a response to AHCA ITN 007-23/24 to operate as aStatewide Medicaid Prepaid Dental Plan.

1. **QUALIFICATION OF PLAN ELIGIBILITY**

I hereby certify my company currently operates as one (1) of the following:

[ ]  HMO Health Maintenance Organization licensed pursuant to Part I of Chapter 641, Florida Statutes, and possess in at least one (1) Florida county a current Florida Certificate of Authority and Health Care Provider Certificate issued by the Florida Department of Financial Services, Office of Insurance Regulation.

OR

[ ]  Prepaid Limited Health Service Organization licensed pursuant to Part I of Chapter 636, Florida Statutes, and possess a current Florida Certificate of Authority issued by the Florida Department of Financial Services, Office of Insurance Regulation.

OR

[ ]  Exclusive Provider Organization that meets the certification requirements of Section 627.6472, Florida Statutes.

OR

[ ]  Accountable Care Organization authorized under federal law.

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**Signature below indicates the respondent’s full acknowledgement of, understanding of, and agreement with the certification identified above in as written and without caveat.**

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| **Respondent Name** |  |  |
|  |  |  |
| **Authorized Official Signature** |  | **Date** |
|  |  |  |
| **Authorized Official Name** |  |  |
|  |  |  |
| **Authorized Official Title** |  |  |

**Failure to submit, Exhibit A-2-a-V2, Qualification of Plan Eligibility, signed by an authorized official may result in the rejection of response.**

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