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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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