



JEB BUSH, GOVERNOR

ALAN LEVINE, SECRETARY

May 25, 2005

FINAL NOTICE

Provider Number

Dear Provider:

This is the final notice and follow-up to the Agency's letters of March 15 and April 19, 2005, regarding Medicaid's surety bond requirement. **Unless exempt, please submit a current and valid original bond or a continuation certificate to ACS State Healthcare, the Medicaid fiscal agent at P.O. Box 7070, Tallahassee, FL 32314-7070.** Please indicate your provider number and tax identification number on the bond. Letters of credit are not acceptable.

As of the date of this letter the Medicaid fiscal agent, ACS State Healthcare, has not received your completed surety bond or exemption form. As a Medicaid DME provider, you are required to have a valid surety bond unless you meet specific exemption criteria. Please refer to the attached form to determine whether this provider location may be exempt. Complete the form and return it to the address listed to submit an original surety bond or to notify us of any exemption.

Section 7 of the Medicaid Provider Agreement states that either party has the right to terminate the agreement upon thirty (30) days written notice by either party. Please be advised that the Agency has elected to exercise its termination rights under Section 7 of the provider agreement. Consequently, the Medicaid provider number listed above will terminate June 30, 2005 unless we receive the bond or statement of exemption before then. Remember, once a Medicaid provider number is terminated it cannot be reactivated and a new application must be submitted to obtain a new provider number.

If you have questions concerning this letter, please call the Provider Enrollment Unit of the Medicaid fiscal agent, ACS State Healthcare, at 1-800-377-8216.

Sincerely,

Alan Strowd, Chief
Medicaid Contract Management



Medicaid Contract Management
2308 Killearn Center Blvd., Suite B200
Tallahassee, FL 32309

AHCA Headquarters
2727 Mahan Drive
Tallahassee, FL 32308

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION
MEDICAID PROVIDER SURETY BOND

MEDICAID PROVIDER NUMBER or TAX ID _____ **BOND NUMBER** _____

Know all men by these presents that

_____ d/b/a _____
(Provider's Name)

with its place of business at _____
(Provider's Physical Address)

City of _____, County of _____, State of _____, as principal,
and _____, a corporation organized and existing under the laws of
(Surety Name)

the State of _____, with its principal place of business at _____
(Surety Address)

City of _____, County of _____, State of _____ and licensed to transact a surety
business in the State of Florida, as surety, are indebted to the State of Florida, Agency for Health Care Administration
(AHCA), in the penal sum of Fifty Thousand Dollars (\$50,000), for which payment principal and surety bind ourselves and
our legal representatives and successors, jointly and severally.

The condition of this obligation is that principal is a Medicaid provider as defined in §409.901(11), Florida Statutes (Fla.
Stat.), and is required by the Agency, pursuant to §409.907(7), Fla. Stat., to post a surety bond in the amount of \$50,000
to insure compliance with the attached provider agreement, pursuant to §409.907, Fla. Stat.

If principal and all of principal's agents and employees faithfully conform to and abide by the provisions of the above
statute, implementing regulations and bulletins, together with all amendatory and supplementary acts, now and hereafter
enacted, and if principal honestly and faithfully applies funds received, and faithfully and honestly performs all obligations
and undertakings made pursuant to the provisions of such statute in the conduct of providing Medicaid services by
principal and by principal's agents and employees, then this obligation shall be null and void; otherwise, it shall be in full
force and effect.

1. The total aggregate liability of the surety shall be limited to the sum of \$50,000 Dollars.
2. This bond and the obligation under the bond shall be deemed to run continuously, and shall remain in full force and effect for one year until and unless the bond is terminated and canceled in the manner provided, the Medicaid provider agreement expires, or as otherwise provided by law.
3. The Agency, acting through the Secretary, reserves the right, at any time, to terminate this bond, except as to any liability already incurred or accrued, by written notice of such termination to the surety delivered or mailed by certified or registered mail. On expiration of the period designated in such notice, which period shall be not less than sixty (60) days from the time the notice was mailed, this bond shall terminate and be of no further force or effect except as to any liability incurred or accrued prior to such termination.
4. Surety reserves the right to terminate this bond at any time, such termination to be effected by surety's giving sixty (60) days written notice, including reason, by certified or registered mail to: The principal and ACS State Healthcare, Provider Enrollment Office, P.O. Box 7070, Tallahassee, Florida, 32314-7070. The liability of surety on this bond shall cease sixty (60) days after receipt of the termination notice by Agency and principal, or on the filing and acceptance of a new bond whichever first occurs; and the bond shall terminate and be of no further force or effect, except as to any liability, debt, or other obligation incurred or accrued prior to the effective date of such termination. The principal insured under the bond shall, within thirty (30) days of the filing of the notice of termination, provide ACS State Healthcare with a replacement bond.

5. In the event principal and surety, or either of them, is served with notice of any action brought against principal or surety under this bond, written notice of the filing of such action shall be immediately given by principal or surety, as each is served with notice of the action to: ACS State Healthcare, Provider Enrollment Office, P.O. Box 7070, Tallahassee, Florida, 32314-7070.
6. In the event any actions or proceedings are initiated with respect to this bond, the parties agree that the venue shall be Leon County, State of Florida.
7. Should any proceedings be necessary to enforce this bond, AHCA shall be allowed to recover attorney fees, in addition to other sums found due.
8. It is agreed that this bond shall be governed by and construed in accordance with the laws of the State of Florida.
9. Neither this bond nor the obligation of this bond, nor any interest in the bond, may be assigned without the prior, express, and written consent of surety.
10. No right of action shall accrue on account of this bond for the use or benefit of any individual, partnership, corporation, or other entity, other than AHCA.

The premium for which this bond is written is _____ Dollars (\$ _____)

In witness whereof, each party to this bond has caused it to be executed at the place and on the date indicated below.

<p>MEDICAID PROVIDER</p> <p style="text-align: center;">AND</p> <p>SURETY COMPANY</p> <p style="text-align: center;">OR</p> <p>RESIDENT AGENT</p>	<p style="font-size: 3em;">{</p> <p style="font-size: 3em;">{</p> <p style="font-size: 3em;">{</p>	<p>By: _____</p> <p style="padding-left: 20px;">(Authorized Corporate Officer)</p> <p>Capacity: As _____</p> <p>By: _____</p> <p style="padding-left: 20px;">(Authorized Corporate Officer)</p> <p>Capacity: As _____</p> <p>By: _____</p> <p style="padding-left: 20px;">(Florida Resident Agent of Surety Company)</p> <p>_____</p> <p style="padding-left: 20px;">(Resident Agent's Street Address)</p> <p>_____</p> <p style="padding-left: 20px;">(City, State, and ZIP Code)</p>
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SIGNED and SEALED in the presence of: _____ and _____

(Witness) _____ (Witness)

Executed at _____, Florida, this _____ day of _____, 20____.

NOTE: If a Florida Resident Agent signs in lieu of the Surety Company Officer then a properly certified copy of the Agent's Power of Attorney must be attached to this bond.