FLORIDA MEDICAID

CHARLIE CRIST
GOVERNOR

HOLLY BENSON
SECRETARY

Permissible Expenditures Certification Form
for the Florida Low Income Pool

_____
(Provider name)

Provider name and address (include county): _____

Prepared by: _____

Contact Phone: _____

Contact email: _____

Medicaid Provider Number: _____ Confirmation #: _____

Reporting Period: From: _____ To: _____

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF _____
(Provider Type)

I Hereby Certify That I Have Examined The Accompanying Data (Permissible Expenditures) For The Reporting Period Beginning _____ and Ending _____ And That To The Best Of My Knowledge And Belief It Is A True, Correct And Complete Statement Prepared From The Books And Records Of The _____ (provider name) In Accordance With Applicable Instructions, Except As Noted:

_____

_____

_____

I certify that I am familiar with the laws and regulations regarding the provision of health care services under the Florida Medicaid program, including the laws and regulations relating to claims for Medicaid reimbursements and payments, and that the services and expenditures identified in this report were provided in compliance with such laws and regulations.

_____
Signature of Officer or Administrator

_____
Title

_____
Date

Return Completed form to:
Low Income Pool Unit
2727 Mahan Drive, MS# 21
Tallahassee, Florida 32308
Fax: (850) 922-0461

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