EXHIBIT A-2-a
QUALIFICATION OF PLAN ELIGIBILITY

RESPONDENT'S NAME:

1. IDENTIFICATION OF PLAN TYPE

I hereby certify that my company is submitting a response to DOH23-025ITN to operate as the following plan type:

☐ Managed Medical Assistance Plus Plan

2. SELECTION OF REGIONS

I hereby certify that my company is submitting a response to operate in the following region(s):

☐ Statewide Response

3. QUALIFICATION OF PLAN ELIGIBILITY

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

☐ HMO Health Maintenance Organization and possesses a current Florida Certificate of Authority and Health Care Provider Certificate in at least one (1) Florida county.

OR

☐ Provider Service Network qualified by Section 409.912(1), Florida Statutes and possess a Florida Third Party Administrator License or a subcontract/letter of agreement with a Florida-licensed Third Party Administrator. A copy of the Third Party Administrator license, or subcontract/letter of agreement, must be submitted with the solicitation response.

In addition, the respondent shall complete **Exhibit A-2-b,** Provider Service Network Certification of Ownership and Controlling Interest.

EXHIBIT A-2-a
QUALIFICATION OF PLAN ELIGIBILITY

OR

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

OR

☐ Accountable Care Organization authorized under federal law.

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

_____
Respondent Name

_____ _____
Authorized Official Signature **Date**

_____
Authorized Official Name

_____
Authorized Official Title

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

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