**RESPONDENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **IDENTIFICATION OF RESPONDENT TYPES**

I hereby certify that my company is submitting a reply to DOH17-026 to operate as a Specialty Plan.

1. **QUALIFICATION OF RESPONDENT ELIGIBILITY**

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

HMO Health Maintenance Organization and possess a current Florida Certificate of Authority and Health Care Provider Certificate in at least one Florida county.

**OR**

PSN that possesses 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 reply.

In addition, the Respondent will complete **Exhibit 4,** Provider Service Network Certification of Ownership and Controlling Interest.

**OR**

Exclusive Provider Organization that meets the licensure 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 as written and without caveat.**

**Respondent Name**

**Authorized Official Signature Date**

**Authorized Official Printed Name**

**Authorized Official Title**

**Failure to submit, Exhibit 3, Qualification of Respondent Eligibility, signed by an authorized official may result in the rejection of reply.**