Community Care Plan
The Health Plan with a Heart

ACTIVE PATIENT LOAD ATTESTATION

Provider Name: _____

Provider NPI: _____

Group Name: _____

Tax ID #: _____

Patient Load Information:

Please indicate the number of active patients you are currently managing under the following insurance plans:

1. Medicaid: _____
2. Florida Healthy Kids: _____
3. Commercial Insurance: _____

Attestation:

I, _____, hereby attest that the information provided above regarding my current patient load is accurate to the best of my knowledge. I understand that this information is required pursuant to Florida Statute 409.9122 (12), F.S., and that providing false information may result in penalties or legal consequences.

Furthermore, I acknowledge that maintaining an accurate record of my active patient load is essential for ensuring the quality and continuity of care for my patients and for fulfilling the requirements of my contract with Community Care Plan.

Signature: _____ Date: _____

Submission Instructions:

Please return this completed form to Community Care Plan by fax or email within 15 days of receipt.

Fax Number: 855-819-9506

Email Address: CCP.provider@ccpcares.org

For any questions or concerns regarding this form, please contact Community Care Plan Provider Operations at 855-819-9506.

Thank you for your cooperation.