OFFICE OF INSURANCE REGULATION
PROPERTY & CASUALTY PRODUCT REVIEW

HEALTH CARE PROVIDER CERTIFICATION OF ELIGIBILITY FOR PIP BENEFITS

(This form is to be provided to the insurer providing coverage for injured patient)

I, _____, _____ pursuant to Section
(Print or type name) (Print or type title)
627.736(1)(a), Florida Statutes, under oath do swear and attest, based on the signing health care provider's personal knowledge, under penalty of perjury, that medical benefits as described in Section 627.736(1)(a), Florida Statutes are being provided by:

(Check all applicable boxes)

☐ 1. An entity wholly owned by one or more physicians licensed under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, or dentists licensed under chapter 466 or by such practitioner or practitioners and the spouse, parent, child, or sibling of that practitioner or those practitioners.

Please list the name(s), address(es), Florida practice license number(s) (including prefixes and suffixes, if any), and the percentage owned by each licensed health care practitioner having an ownership interest in the clinic. (Please add additional pages if necessary)

Name	Address	License Number	% Owned
Enter total from family members, below	→		
	Add all percentages owned. This sum must equal 100%		**100%**

Identification of Family Member Owners (When Applicable): Please provide requested information for the spouse, child, sibling or parent of the health care practitioner who has an ownership interest in the clinic, and the percentage owned. (Please add additional pages if necessary.)

Name	Address	Relationship to Practitioner	% Owned
	Enter % here and on Family Member Total, above (Add all percentages owned)		

☐ 2. An entity wholly owned, directly or indirectly, by a hospital or hospitals.

Name of Hospital:_____

Explanation of ownership relationship to Hospital:

_____

_____

_____

_____

☐ 3. A health care clinic licensed under Sections 400.990-400.995 Florida Statutes that is:

☐ a. Accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association, the Commission on Accreditation of Rehabilitation Facilities, or the Accreditation Association for Ambulatory Health Care, Inc.; or

Please state the name of the accrediting agency and the date of current accreditation:

_____Date_____

☐ b. A health care clinic that:

☐ 1. Has a medical director licensed under chapter 458, chapter 459, or chapter 460; and give the full name of Medical Director shown on the Board license and telephone number where director may be contacted.

Name on License_____ Lic.No._____

Telephone #_____

☐ 2. Has been continuously licensed for more than 3 years or is a publicly traded corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange; and

- HCC License #_____, effective date first HCC license_____
- Name of Exchange (i.e. NYSE, NASDAQ) and Exchange symbol for company:
  _____

☐ 3. Provides at least four of the following medical specialties:

☐ General medicine	☐ Orthopedic medicine	☐ Radiography
☐ Physical therapy	☐ Physical medicine	☐ Physical rehabilitation
☐ Prescribing or dispensing outpatient prescription medication	☐ Laboratory services	

Note: Items 3. b. 1, 2 & 3 above are all required for eligibility.

_____ _____
(Signature) Executive Officer, Medical or Clinic Director (Title)

_____ _____
(Print or Type Name) (Board or Department of Health License No. with suffix)

_____
(Corporate Name of Entity or Clinic, as filed with Florida Department of State, i.e. Inc., LLC, LLP, P.A., etc.)

_____
Address) (City) (State) (Zip) (Phone)

(AFTER AN INITIAL, NOTARIZED SUBMISSION TO AN INSURER THIS FORM MAY BE COPIED FOR SUBMISSION TO THAT INSURER, PROVIDED THERE HAS BEEN NO CHANGE TO THE INFORMATION CONTAINED ON THE FORM.)

Notarization of Health Care Provider:

STATE OF _____
COUNTY OF_____

Sworn to and subscribed before me this _____day of _____, 20__, by _____.

Personally Known_____ OR Produced Identification_____(Type of Identification Produced)

Notary Signature _____

My commission expires: _____