MAP-347
(Rev. 1/09)

KENTUCKY MEDICAID PROGRAM
STATEMENT OF AUTHORIZATION FOR PAYMENT

I hereby declare that I, _____,
(Licensed Professional)

_____, a duly licensed _____,
(Medicaid Provider Number)

have entered into a contractual agreement with the following:

Transformations hope for today's families LLC
(Clinic/Corporation or Facility Name)

4010 Dupont Circle Suite 582 Louisville KY 40207
(Street Address/P.O. Box Number) (City, State Zip Code)

to provide professional services. I authorize payment including Medicaid/Medicare cross-overs to the following:

Transformations hope for today's families LLC
(Clinic/Corporation or Facility Name)

from the Kentucky Medicaid Program for covered services provided by me and specified by the criteria of our contract. I understand that I, personally shall not bill the Kentucky Medicaid Program for any service that is reimbursed to the following:

Transformations hope for today's families LLC
(Clinic/Corporation or Facility Name)

as part of contractual agreement, and further that Clinic/Corporation or Facility Name listed above shall be responsible for refunding any overpayments made for services rendered.

_____
Social Security Number

_____
NPI (National Provider Identifier) of Individual

7100269220
Kentucky Medicaid Provider Number of Clinic/Corporation or Facility

61-1351752
Federal Employer Identification Number of Clinic/Corporation or Facility

_____
Date Contract Effective

_____
Signature of Provider

_____
Date of Signature

_____
Witnessed by (Signature)

_____
Date of Signature

Please return form to: Kentucky Medicaid, P.O. Box 2110, Frankfort, KY 40602-2110