

State Of Florida
PROVIDER ENROLLMENT APPLICATION

PROVIDER SUBMISSION INFORMATION	
Application Type GROUP	
Enrollment Type ENROLLMENT	
Provider Type COMMUNITY BEHAVIORAL HEALTH SERVICES	
Is this a Crossover only application? NO	
Is this application based on a change of ownership (CHOW)? NO	
PROVIDER IDENTIFYING INFORMATION	
Name of Business or Individual TU FAMILIA HEALTH CENTER INC	Title/Degree
Doing Business As (D/B/A)	Ownership Code PRIVATELY OWNED, FOR PROFIT
Tax ID / Type 861586772 / FEIN	Practice Type
LICENSE AND MORE IDENTIFYING INFORMATION	
DEA Number	Medicare Number
Lic. Source NA	License Number HCC13111
License State FL	CLIA Number
CONTACT INFORMATION	
Contact Name ROSS, JUAN	Contact Number (305)303-2240
Contact Email rossconsultingandcredentialing@gmail.com	
SERVICE LOCATION ADDRESS INFORMATION	
Address Type SERVICELOCATION	Email Address jorgeluisrdc89@gmail.com
Address 375 W 19TH ST	Phone (786)862-4351
City HIALEAH	Fax NaN
County DADE	State, Zip FL 33010-2532
ADDITIONAL SERVICE LOCATION ADDRESSES	
MAIL TO ADDRESS INFORMATION	
Address Type MAILTO	Email Address jorgeluisrdc89@gmail.com
Address 375 W 19TH ST	Phone (786)862-4351

City HIALEAH	Fax NaN
County DADE	State, Zip FL 33010-2532

PAY TO ADDRESS INFORMATION

Address Type PAYTO	Email Address jorgeluisrdc89@gmail.com
Address 375 W 19TH ST	Phone (786)862-4351
City HIALEAH	Fax NaN
County DADE	State, Zip FL 33010-2532

HOME/CORP OFFICE ADDRESS INFORMATION

Address Type HEMPCORPORATEOFFICE	Email Address jorgeluisrdc89@gmail.com
Address 375 W 19TH ST	Phone (786)862-4351
City HIALEAH	Fax NaN
County DADE	State, Zip FL 33010-2532

PROVIDER NPI

NPI 1699366682

SPECIALTY INFORMATION

Primary Specialty COMMUNITY MENTAL HEALTH SERVICES	Primary Taxonomy 261QM0801X
Secondary Specialty	Secondary Taxonomy
Third Specialty	Third Taxonomy
Fourth Specialty	Fourth Taxonomy

PROVIDER CONTRACTS

Provider Contract Comm Mntl Hlth Srvc

PAYMENT METHOD

- If you are an individual or group provider who will bill and receive direct payment from Medicaid you must complete the EFT Agreement.
- If you are an individual who will not receive direct payment and your group always bill select EFT Agreement Exception Request.
- If you work for a group AND you will also bill separately for yourself you must complete the EFT Agreement.

You Selected: **Electronic Funds Transfer(EFT) Agreement**

EFT AGREEMENT

Electronic Funds Transfer (EFT) Agreement:

The undersigned authorize the fiscal agent for the Florida Medicaid Program to make deposits to the checking or savings account at the

depository bank indicated.

The individual(s) listed below are authorized by the provider or its agent to initiate, modify or terminate an EFT enrollment.

Name 1 LOPEZ FLORES, MARIO C	Name 2
Name 3	Name 4
Name On Bank Account TU FAMILIA HEALTH CENTER INC	Bank Account Number 4369976936
ABA Routing Number 067014822	Bank Name TD BANK, NA
Bank Branch	City MOUNT LAUREL
State, Zip NJ 08054 -3918	Phone Number (800)281-0025
Grouping Preference Type NPI	Grouping Preference Number 1699366682

OWNERS AND OPERATORS

This Is An Application for A Group, Facility, or Organization Applicant:

You have indicated that you are a group, facility or organization applicant, list all shareholders (five percent or more ownership), all partners of your business and subcontractors AND all individual officers, directors, managers, the financial records custodian, the medical records custodian, and all individuals who hold signing privileges on your depository account, and the requested information for each.

Owner Name LOPEZ FLORES, MARIO C	Title
Tax ID / Type 489398301 / SSN	Relationship OWNER
Owner Percent 100%	Lic. Source NA
License Number	Date of Birth 3/28/1999
Phone (786)862-4351	Address 881 WESWT 38TH ST
City HIALEAH	State FL
Zip 33012	
Owner Name LOPEZ FLORES, MARIO C	Title
Tax ID / Type 489398301 / SSN	Relationship FINANCIAL RECORDS CUSTODIAN
Owner Percent 0%	Lic. Source NA
License Number	Date of Birth 3/28/1999

Phone (786)862-4351	Address 881 WESWT 38TH ST
City HIALEAH	State FL
Zip 33012	
Owner Name LOPEZ FLORES, MARIO C	Title
Tax ID / Type 489398301 / SSN	Relationship MEDICAL RECORDS CUSTODIAN
Owner Percent 0%	Lic. Source NA
License Number	Date of Birth 3/28/1999
Phone (786)862-4351	Address 881 WESWT 38TH ST
City HIALEAH	State FL
Zip 33012	

APPLICANT HISTORY

Have you, or any owner(s)/operator(s) ever:

Been convicted of a felony, had adjudication withheld on a felony, pled nolo contendere to a felony, or entered into a pre-trial agreement for a felony?

NO

Had any disciplinary action taken against any business or professional license held in this or any other state or surrendered a license in this or any state?

NO

Been denied enrollment, been suspended or excluded from Medicare or Medicaid in any state, or been employed by a corporation, business or professional association that has ever been suspended or excluded from Medicare or Medicaid in any state?

NO

Had suspended payments from Medicare or Medicaid in any state, or been employed by a corporation, business or professional association that ever had suspended payments from Medicare or Medicaid in any state?

NO

Owes money to Medicaid or Medicare that has not been paid?

NO

Have ownership in any other Medicaid enrolled business?

NO

"For the purpose of establishing eligibility to receive direct or indirect payment for services rendered to recipients of the Florida Medicaid Program, I understand that, under Section 409.920(2), Florida Statutes, knowingly submitting false or misleading information or statements to the Medicaid program for the purpose of being accepted as a Medicaid provider is a felony and is sufficient cause for termination from the Florida Medicaid Program. I further understand that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws. I understand that I am responsible for the information presented on this application and that the information is true, accurate, and complete. Furthermore,

I agree to abide by the provisions of this provider agreement from the date it is effective per Section 409.907(11), Florida Statutes.

Furthermore, I understand that it is my responsibility to notify Medicaid's fiscal agent of any future changes to the information on this application, including but not limited to, a change of address, group affiliation, ownership, officers, directors, affiliated persons, tax identification number, or EFT bank account."

Signature - Provider

LOPEZ FLORES, MARIO C

Date Signed - Provider

09/08/2024

For Official Use Only - Application Tracking Number

1014705