I hereby declare that I, {Enter Contractor Name}

a duly licensed {Enter Type of License}

have entered into a

contractual agreement {Enter Contract Number}

with {Enter Health Department Name}

{Enter Department Address}

{Enter Department City}, KY {Enter Department Zip}

to provide professional services.

I authorize payment to

{Enter Health Department Name}

from the Kentucky Medical Assistance Program for all services provided by me under the terms of our contract. I understand that I, personally, cannot bill the Kentucky Medical Assistance Program for any service that is reimbursed to

{Enter Health Department Name}

as part of our contractual agreement.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Signature of Professional) (Date Signed)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(License and/or Certificate #) (Specialty)