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.

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(Signature of Professional) (Date Signed)

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

(License and/or Certificate #) (Specialty)