



**Florida Department of Education
Division of Vocational Rehabilitation**

INSTRUCTIONS – HOW TO BECOME A GROUP MEDICAL VENDOR

Thank you for your interest in becoming a certified **Group Medical Vendor** with the Florida Department of Education, Division of Vocational Rehabilitation (DVR). We are pleased to have the opportunity to enter into this partnership with you to assist our customers in preparing for, securing, regaining, or retaining employment.

A Group Medical Vendor is a healthcare organization that accepts responsibility for maintaining qualified and properly licensed/credentialed practitioners; and all employees, partners, and associates that fall under the organization's federal tax ID number. This process excludes psychologists which go through a different credentialing process.

- 1. Register with the MyFloridaMarketPlace (MFMP)** statewide electronic procurement system at: <https://vendor.myfloridamarketplace.com/>. This web-based procurement system is designed to streamline interactions between vendors and state government entities.

Registering with MFMP is a very important step because this system is essential in processing payments to a vendor for their commodities or services.

This online registration must take place prior to DVR's Group Medical Vendor Application process being finalized. If you experience problems completing your MFMP registration, please contact the MFMP Customer Service Help Desk at 1-866-352-3776.

***Vendors providing direct services to eligible customers are exempt from the 1% fee that MFMP usually charges, even though vendors must agree that they will accept the fee. There will be a disclaimer on all DVR authorizations that ensures that DVR vendors providing direct customer services are not subject to this fee.

- 2. The Group Medical Vendor Application and notarized attestation must be completed, signed and mailed to the address listed at the bottom of the application.**

If you have any questions, comments, or concerns please do not hesitate to contact the Vendor Certification Unit at **1-800-451-4327** or **850-245-3401**. We can also be contacted via email at vrvendors@vr.fldoe.org

We look forward to working with you in the future.

The Vendor Certification Unit



**DIVISION OF VOCATIONAL REHABILITATION
GROUP MEDICAL VENDOR APPLICATION**

(Please Type or Print the Following Information)

MYFLORIDAMARKETPLACE VENDOR NUMBER: _____
Business Federal Employer Identification or Social Security Number.

NAME OF BUSINESS (as registered in MyFloridaMarketPlace): _____

DOING BUSINESS AS (if applicable): _____

LOCATION ADDRESS: _____

City	State	Zip Code + 4 Digit
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MAILING ADDRESS: _____

City	State	Zip Code + 4 Digit
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REMIT ADDRESS: _____

City	State	Zip Code + 4 Digit
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TELEPHONE NUMBER: _____ **FAX NUMBER:** _____

CONTACT NAME AND TITLE: _____

CONTACT EMAIL ADDRESS: _____

CONTACT PHONE NUMBER: _____

MEDICAL GROUP SPECIALTY, e.g. Cardiology, Family Practice, Anesthesiology, Pediatrics, etc.:

TO YOUR KNOWLEDGE, DO YOU HAVE ANY RELATIVES WORKING IN THE DEPARTMENT OF EDUCATION? **Circle One:** **YES** **NO**

IF YES, PLEASE INDICATE WHO: _____



**Vocational
Rehabilitation**

GROUP MEDICAL VENDOR APPLICATION (Page 2)

(Please Type or Print the Following Information)

PLEASE READ AND SIGN BELOW:

I/We will accept and render services to customers of the Division of Vocational Rehabilitation on a non-discriminatory basis without regard to race, color, disability or national origin. I/We agree to comply with the Americans with Disabilities Act of 1990 as appropriate to the business.

Signature

Date

Print Name

IS YOUR APPLICATION COMPLETE?

- Registered in MyFloridaMarketPlace
 - Notarized attestation of group medical vendor status form
 - Signed and dated application
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Please mail the application and notarized attestation to:

**Florida Department of Education
Division of Vocational Rehabilitation
Vendor Certification Unit
2002 Old Saint Augustine Road, Bldg. A
Tallahassee, FL 32301-4862
Fax Number: 850-245-3394**

**If you have any questions that pertain to this application, please contact
Vendor Certification Unit at 1-800-451-4327 or 850-245-3401
or e-mail: VRVendors@vr.fldoe.org**

State of Florida, Department of Education
Division of Vocational Rehabilitation

ATTESTATION OF GROUP MEDICAL VENDOR STATUS

As a condition of becoming a certified vendor to provide medical services on behalf of the Department of Education / Division of Vocational Rehabilitation (DOE/DVR), _____ (certifiable entity) hereby attests that he/she/it and all or his/her/its employees/partners/associates, e.g., physicians, therapists, nurses, etc., who will provide medical/therapeutic services to DVR clients will maintain current and appropriate licensure and other necessary credentials as required by above certifiable entity and/or local/regional hospitals or other health care institutions where said employees/partners/associates may provide medical services to DVR clients.

Additionally, _____ (certifiable entity) ensures a minimal liability insurance policy of \$1,000,000 is held by respective employees/partners/associates or comparable liability coverage is maintained by the certifiable entity.

Additionally, _____ (certifiable entity) agrees and shall present proof of above referenced credentials and/or insurance policies upon request by the DOE/DVR in order to maintain a current Qualified Vendor Certification Status. Failure to do so will result in revocation of its certification status and termination of all rights to provide medical services by the certifiable entity and its respective employees/partners/associates, including termination of any current certifications.

The _____ (certifiable entity) further understands that at any time the DOE/DVR determines that the certifiable entity is in violation of this attestation or vendor certification requirement(s) that the DOE/DVR shall terminate this certification and may withhold payments for any services that were provided to clients up to the time that default occurred.

This certification is in effect for five years or until mutually cancelled by either party or by default as determined by DOE/DVR.

 (Certifiable Entity)
 BY: _____

 (*Printed Name of Authorized Representative*)

 (Signatory Capacity)

 (Address)

 (Telephone)

 (Fax)

 (*Date*)

STATE OF FLORIDA
 COUNTY OF _____
 Sworn to and subscribed before me this ____ day of _____, 20__ by _____

 (Name of Person Making Statement)

 (*Signature of Notary Public*)
 (*Print, Type, or Stamp*)

 (Commissioned Name of Notary Public)
 Personally known ____ or Produced Identification _____

 Type of Identification produced _____
