

STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION

FILED
AHCA
AGENCY CLERK

2017 APR 12 A 8:30

STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION,

Petitioner,

DOAH Case No. 15-3117MPI
MPI CASE NO.: 2015-0002428
C.I. NO.: 11-2538-000
PROVIDER NO.: 010020000
NPI NO.: 1780667923
LICENSE NO.: 4411

vs.

SOUTH BROWARD HOSPITAL
DISTRICT d/b/a MEMORIAL REGIONAL
HOSPITAL,


RENDITION NO.: AHCA-17-0256^{S-MDO}

Respondent.

FINAL ORDER

THE PARTIES resolved all disputed issues and executed a Settlement Agreement. The parties are directed to comply with the terms of the attached settlement agreement. Based on the foregoing, this file is **CLOSED**.

DONE and ORDERED on this the 10th day of April, 2017, in Tallahassee,
Florida.



JUSTIN M. SENIOR, SECRETARY
Agency for Health Care Administration

A PARTY WHO IS ADVERSELY AFFECTED BY THIS FINAL ORDER IS ENTITLED TO A JUDICIAL REVIEW WHICH SHALL BE INSTITUTED BY FILING ONE COPY OF A NOTICE OF APPEAL WITH THE AGENCY CLERK OF AHCA, AND A SECOND COPY ALONG WITH FILING FEE AS PRESCRIBED BY LAW, WITH THE DISTRICT COURT OF APPEAL IN THE APPELLATE DISTRICT WHERE THE AGENCY MAINTAINS ITS HEADQUARTERS OR WHERE A PARTY RESIDES. REVIEW PROCEEDINGS SHALL BE CONDUCTED IN ACCORDANCE WITH THE FLORIDA APPELLATE RULES. THE NOTICE OF APPEAL MUST BE FILED WITHIN 30 DAYS OF RENDITION OF THE ORDER TO BE REVIEWED.

Copies furnished to:

South Broward Hospital District
d/b/a Memorial Regional Hospital
2900 Corporate Way
Miramar, FL 33025
(U.S. mail)

Joanne B. Erde, Esquire
Duane Morris, LLP
200 South Biscayne Blvd., Suite 3400
Miami, Florida 33131
jerde@duanemorris.com
(E-Mail)

Joseph M. Goldstein, Esquire
Shutts & Bowen LLP
200 East Broward Blvd., Suite 2100
Fort Lauderdale, FL 33301
jgoldstein@shutts.com
(E-Mail)

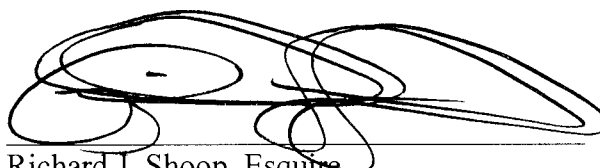
Health Quality Assurance
(E-Mail)

Kelly Bennett, Chief, MPI
(E-Mail)

Bureau of Financial Services
(E-Mail)

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished to the above named addressees by U.S. Mail or other designated method on this the 12th day of ~~March~~ April, 2017.



Richard J. Shoop, Esquire
Agency Clerk
State of Florida
Agency for Health Care Administration
2727 Mahan Drive, MS #3
Tallahassee, Florida 32308-5403
(850) 412-3689/FAX (850) 921-0158

**STATE OF FLORIDA
AGENCY FOR HEALTH CARE ADMINISTRATION**

AGENCY FOR HEALTH CARE
ADMINISTRATION,

Petitioner,

vs.

SOUTH BROWARD HOSPITAL
DISTRICT d/b/a MEMORIAL REGIONAL
HOSPITAL,

Respondent.

CASE NO.: 15-3117MPI
MPI REC ID: 2015-0002428
C.I. NO.: 11-2538-000
PROVIDER NO.: 010020000
NPI NO: 1780667923
LICENSE NO.: 4411

SETTLEMENT AGREEMENT

Petitioner, the **STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION** (“AHCA” or “Agency”), and Respondent, **SOUTH BROWARD HOSPITAL DISTRICT d/b/a MEMORIAL REGIONAL HOSPITAL**, provider number 010020000 (“PROVIDER”), by and through the undersigned, hereby stipulate and agree as follows:

1. The parties agree to settle DOAH Case No. 13-3117MPI (this matter) wherein PROVIDER filed a petition for formal administrative hearing regarding the Final Audit Report issued by AHCA on April 13, 2015.
2. PROVIDER is a Medicaid provider in the State of Florida, provider number 010020000, and was a provider during the audit period.
3. A preliminary audit dated November 3, 2014, was sent to PROVIDER indicating that the Agency had determined PROVIDER was overpaid \$191,418.50. On April 13, 2015, a Final Audit Report was sent to PROVIDER indicating that the Agency had determined PROVIDER was overpaid \$191,418.50.

4. In its Final Audit Report, the Agency notified PROVIDER that a review performed by the Agency's Office of the Inspector General, Bureau of Medicaid Program Integrity ("MPI") of PROVIDER'S Medicaid claims that were rendered during the period of January 1, 2007 through December 31, 2007, indicated that certain claims, in whole or in part, were inappropriately paid by AHCA. The Agency sought repayment of this overpayment, in the amount of one hundred ninety-one thousand, four hundred eighteen dollars and fifty cents (\$191,418.50) and assessed the following sanctions in accordance with Sections 409.913(15), (16) and (17), Florida Statutes, and Rule 59G-9.070(7), Florida Administrative Code against PROVIDER: a fine in the amount of two thousand, five hundred dollars (\$2,500.00) for violation(s) of Rule 59G-9.070(7)(c), Florida Administrative Code; and costs in the amount of two thousand, five hundred fifty-three dollars and 41 cents (\$2,553.41). The total amount due was one hundred ninety-six thousand, four hundred seventy-one dollars and ninety-one cents (\$196,471.91).

5. In response to the Final Audit Report dated April 13, 2015, PROVIDER timely filed a Petition for Formal Administrative Hearing.

6. In order to resolve this matter without further administrative proceedings, and based upon additional information received and reviewed by AHCA during the pendency of litigation, PROVIDER and AHCA agree as follows:

- A. AHCA agrees to accept the payment set forth below in settlement of the overpayment, fine and costs arising from the above-reference audit.
- B. PROVIDER agrees to pay AHCA the sum of one hundred forty-three thousand, five hundred sixty-three dollars and eighty-seven cents (\$143,563.87), which includes a total overpayment in the amount of one hundred thirty-eight thousand, five hundred ten dollars and forty-six cents (\$138,510.46) plus a

sanction of two thousand, five hundred dollars (\$2,500.00) and costs of two thousand, five hundred fifty-three dollars and forty-one cents (\$2,553.41).

C. Any monies PROVIDER has paid to AHCA pursuant to the involuntary lien shall be retained by AHCA as payment of the agreed-upon amount due of one hundred forty three thousand, five hundred sixty-three dollars and eighty-seven cents (\$143,563.87). As of April 13, 2015, AHCA has received payments from the PROVIDER totaling one hundred ninety-six thousand, four hundred seventy-one dollars and ninety-one cents (\$196,471.91). PROVIDER shall be refunded any amount collected in excess of the agreed upon amount of one hundred forty three thousand, five hundred sixty-three dollars and eighty-seven cents (\$143,563.87), as follows:

- i. Within thirty (30) days following the issuance of a Final Order in this case, Financial Services shall forward the PROVIDER a Refund Application reflecting the refund due to the PROVIDER;
- ii. Once Financial Services has received the signed Refund Application, the refund will be processed.
- iii. Payment of the refund shall be made within thirty (30) days of Financial Services' receipt of the signed Refund Application.

D. PROVIDER and AHCA agree that full payment, as set forth above, and already made, resolves and settles this case completely and releases both parties from any administrative or civil liabilities arising from any review determinations relating to the claims as referenced in audit C.I. No.: 11-2538-000.

E. PROVIDER agrees that it shall not re-bill the Medicaid Program in any manner for the claims that are the subject of the review in this case as specifically identified in the Final Audit Report.

7. AHCA and PROVIDER each reserve the right to enforce this Agreement under the laws of the State of Florida, the Rules of Medicaid Program, and all other applicable rules and regulations.

8. This settlement does not constitute an admission of wrongdoing or error by either party with respect to this or any other matter.

9. The signatories to this Agreement, acting in a representative capacity, represent that they are duly authorized to enter into this Agreement on behalf of the respective parties.

10. This Agreement shall be construed in accordance with the provisions of the laws of Florida. Venue for any action arising from this Agreement shall be in Leon County, Florida.

11. This Agreement constitutes the entire agreement between PROVIDER and AHCA, including anyone acting for, associated with or employed by them, concerning this matter and supersedes any prior discussions, agreements or understandings regarding this matter; there are no promises, representations or agreements between PROVIDER and AHCA other than as set forth herein. No modification or waiver of any provision shall be valid unless a written amendment to the Agreement is completed and properly executed by the parties.

12. This is an Agreement of Settlement and Compromise, made in recognition that the parties may have different or incorrect understandings, information and contentions as to facts and law, and with each party compromising and settling any potential correctness or incorrectness of its understandings, information and contentions as to facts and law, so that no misunderstanding or misinformation shall be a ground for rescission hereof;

13. PROVIDER expressly waives its right to any hearing pursuant to sections 120.569 or 120.57, Florida Statutes, the making of findings of fact and conclusions of law by the Agency, and all further and other proceedings to which it may be entitled by law or rules of the Agency regarding this matter. PROVIDER further agrees that it shall not challenge or contest any Final order entered in this matter that is consistent with the terms of this Agreement in any forum now or in the future available to it, including the right to any administrative proceedings, circuit or federal court action or any appeal.

14. PROVIDER does hereby discharge the State of Florida, Agency for Health Care Administration, its agents, representative, and attorneys of and from all claims demands, actions, causes of action, suits, damages, losses and expenses, of any and every nature whatsoever, arising in this matter, AHCA's action herein including, but not limited to, any claims that were or may be asserted in any federal or state court or administrative forum, including any claims arising out of this Agreement; provided, however, PROVIDER does not discharge the State of Florida, Agency for Health care Administration, regarding any other matters related to AHCA's payments, practices, policies or audits of services rendered to undocumented aliens.

15. The parties agree to bear their own attorneys' fees and costs, if any.

16. This Agreement is and shall be deemed jointly drafted and written by all parties to it and shall not be construed or interpreted against the party originating or preparing it.

17. To the extent that any provision of this Agreement is prohibited by law for any reason, such provision shall be effective to the extent not so prohibited, and such prohibition shall not affect any other provision of this Agreement; provided, however, if the entitlement to a refund to PROVIDER in paragraph 6 is prohibited, or if a Final Order has not been issued within 180

days from the date of signature by PROVIDER, PROVIDER shall have the right to void this Agreement.

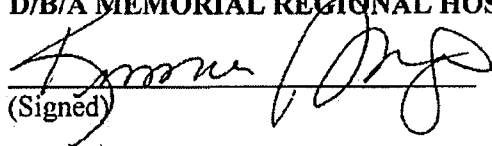
18. This Agreement shall inure to the benefit of and be binding on each party's successors, assigns, heirs, administrators, representatives and trustees.

19. All times stated herein are of the essence of this Agreement.

20. This Agreement shall be in full force and effect upon execution by the respective parties in counterpart.

THE REMAINDER OF THIS PAGE IS INTENTIONALLY BLANK

**SOUTH BROWARD HOSPITAL DISTRICT,
D/B/A MEMORIAL REGIONAL HOSPITAL**




(Signed)

Dated: 1/16, 2017

BY: Kimone Stratos
(Print Name and Title)

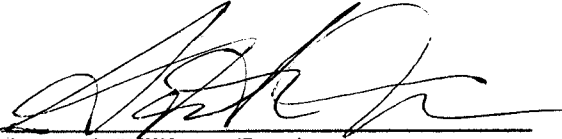
**AGENCY FOR HEALTH CARE
ADMINISTRATION**

2727 Mahan Drive, Bldg. 3, Mail Stop #3
Tallahassee, FL 32308-5403



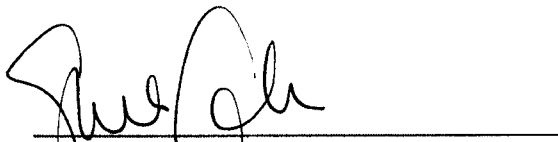
Eric W. Miller
Inspector General

Dated: 4/10, 2017



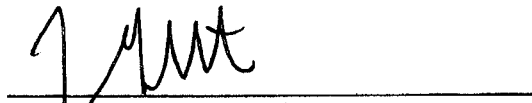
Stuart F. Williams, Esquire
General Counsel

Dated: 3/19, 2017



Shena L. Grantham, Esquire
Medicaid Admin. Lit. Chief Counsel

Dated: 3/16, 2017



Joseph Goldstein, Esquire
Shuts & Bowen LLP

Dated: 2/28/17, 2017



RICK SCOTT
GOVERNOR

ELIZABETH DUDEK
SECRETARY

CERTIFIED MAIL No.: 7012 1010 0003 2495 2540

April 13, 2015

Provider No: 010020000
NPI No: 1780667923
License No.: 4411

MEMORIAL REGIONAL HOSPITAL
SOUTH BROWARD HOSP.DIST.
2900 CORPORATE WAY
MIRAMAR, FL 33025

In Reply Refer to
FINAL AUDIT REPORT
C.I.: No. 11-2538-000

Dear Provider:

The Agency for Health Care Administration (Agency), Office of Inspector General, Bureau of Medicaid Program Integrity, has completed a review of claims for Medicaid reimbursement for dates of service during the period January 1, 2007, through December 31, 2007. A preliminary audit report dated November 3, 2014 was sent to you indicating that we had determined you were overpaid \$191,418.50. Based upon a review of all documentation submitted, we have determined that you were overpaid \$191,418.50 for services that in whole or in part are not covered by Medicaid. A fine of \$2,500.00 has been applied. The cost assessed for this audit is \$2,553.41. The total amount due is \$196,471.91.

Be advised of the following:

- (1) In accordance with Sections 409.913(15), (16), and (17), Florida Statutes (F.S.), and Rule 59G-9.070, Florida Administrative Code (F.A.C.), the Agency shall apply sanctions for violations of federal and state laws, including Medicaid policy. This letter shall serve as notice of the following sanction(s):
 - A fine of \$2,500.00 for violation(s) of Rule Section 59G-9.070(7) (c), F.A.C.
- (2) Pursuant to Section 409.913(23) (a) F.S., the Agency is entitled to recover all investigative, legal, and expert witness costs.

This review and the determinations of overpayment were made in accordance with the provisions of Section 409.913, F.S. In determining payment pursuant to Medicaid policy, the Medicaid program utilizes descriptions, policies and the limitations and exclusions found in the Medicaid provider handbooks. In applying for Medicaid reimbursement, providers are required to follow the guidelines set

2727 Mahan Drive • Mail
Stop # 6
Tallahassee, FL 32308
AHCA.MyFlorida.com



Facebook.com/AHCAFlorida
Youtube.com/AHCAFlorida
Twitter.com/AHCA_FL
SlideShare.net/AHCAFlorida

EXHIBIT 1

forth in the applicable rules and Medicaid fee schedules, as promulgated in the Medicaid policy handbooks, bulletins, and the Medicaid provider agreement. Medicaid cannot pay for services that do not meet these guidelines.

Emergency Medicaid for Aliens (EMA) is a Medicaid limited coverage program in which coverage is only for the duration of the emergency. Definitions for Emergency Medical Condition, Emergency Services and Care or Medical Necessity, may be found in the Florida Medicaid Provider General Handbook. Other relevant definitions may be found in the Florida Administrative Codes, Florida Statutes and in federal law.

Below is a discussion of the particular guidelines related to the review of EMA claims and an explanation of why these claims do not meet Medicaid requirements. A list of the paid claims affected by this determination is attached.

REVIEW DETERMINATION(S)

The Florida Medicaid Provider General Handbook(s), 2004, 2007, pages 3-19, establishes Limited Coverage Categories and Program Codes for programs with limited Medicaid benefits. Medicaid policy related to the program, Emergency Medicaid for Aliens, is further described. The Florida Hospital Services Coverage and Limitations Handbook, 2005, page 2-7, also refers to Emergency Medicaid for Aliens policy. These policy references state: "Eligibility can be authorized only for the duration of the emergency. Medicaid will not pay for continuous or episodic services after the emergency has been alleviated." The Florida Medicaid Provider Reimbursement Handbooks UB-92, 2004, page 2-9 and UB-04, 2007, page 2-7 state: "Medicaid coverage of inpatient services for non-qualified, non-citizens is limited to emergencies, newborn delivery services and dialysis services."

A medical record review was performed by a medical review team including a peer physician reviewer who determined the point at which the alien recipient's emergent complaint was alleviated. Medicaid policy does not allow payment of claims for services rendered beyond the date the emergency has been alleviated. Although medical necessity may continue to exist, Medicaid is not responsible for payment of those continuing services. Consequently, the inpatient services billed to and paid by Medicaid beyond the peer reviewer's determined date of alleviation are identified as an overpayment and are subject to recoupment.

In instances where hospital observation days were allowed, claims were adjusted to allow the outpatient per diem for observations, and the difference was identified as an overpayment and subject to recoupment.

In instances where the medical record was not received or was incomplete, the related claim was denied. The Provider General Handbook(s) 2004, 2007, pages 5-8, states the following:

"Incomplete records are records that lack documentation that all requirements or conditions for service provision have been met. Medicaid may recover payment for services or goods when the provider has incomplete records or cannot locate the records."

In accordance with Medicaid policies, those claims not supported by documentation are identified as overpayments and subject to administrative sanction and recoupment.

The Medicaid Provider General Handbook, 2003, page 5-3, defines "Overpayment" as:

"Overpayment includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claims, unacceptable practices, fraud, abuse or mistake."

If you are currently involved in a bankruptcy, you should notify your attorney immediately and then provide them a copy of this letter. Please advise your attorney that we require the following information immediately:

- 1) the date of filing of the bankruptcy petition;
- 2) the case number;
- 3) the court name and the division in which the petition was filed (e.g., Northern District of Florida, Tallahassee Division);
- 4) the name, address, and telephone number of your attorney.

If you are not in bankruptcy and you concur with our findings, remit by certified check in the amount of \$196,471.91, which includes the overpayment amount as well as any fines imposed and assessed costs.

The check must be payable to the **Florida Agency for Health Care Administration**.

To ensure proper credit, be certain you legibly record on your check your Medicaid provider number and the C.I. number listed on the first page of this audit report. Please mail payment to:

Medicaid Accounts Receivable - MS # 14
Agency for Health Care Administration
2727 Mahan Drive Bldg. 2, Ste. 200
Tallahassee, FL 32308

Questions regarding procedures for submitting payment should be directed to Medicaid Accounts Receivable, (850) 412-3901.

Pursuant to section 409.913(25)(d), F.S., the Agency may collect money owed by all means allowable by law, including, but not limited to, exercising the option to collect money from Medicare that is payable to the provider. Pursuant to section 409.913(27), F.S., if within 30 days following this notice you have not either repaid the alleged overpayment amount or entered into a satisfactory repayment agreement with the Agency, your Medicaid reimbursements will be withheld; they will continue to be withheld, even during the pendency of an administrative hearing, until such time as the overpayment amount is satisfied. Pursuant to section 409.913(30), F.S., the Agency shall terminate your participation in the Medicaid program if you fail to repay an overpayment or enter into a satisfactory repayment agreement with the Agency, within 35 days after the date of a final order which is no longer subject to further appeal. Pursuant to sections 409.913(15)(q) and 409.913(25)(c), F.S., a provider that does not adhere to the terms of a repayment agreement is subject to termination from the Medicaid program. Finally, failure to comply with all sanctions applied or due dates may result in additional sanctions being imposed.

MEMORIAL REGIONAL HOSPITAL

010020000

C.I. No.: 11-2538-000

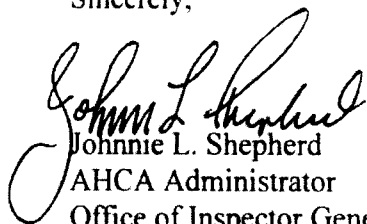
Page 4

You have the right to request a formal or informal hearing pursuant to Section 120.569, F.S. If a request for a formal hearing is made, the petition must be made in compliance with Section 28-106.201, F.A.C. and mediation may be available. If a request for an informal hearing is made, the petition must be made in compliance with rule Section 28-106.301, F.A.C. Additionally, you are hereby informed that if a request for a hearing is made, the petition must be **received by the Agency** within twenty-one (21) days of receipt of this letter. **For more information regarding your hearing and mediation rights, please see the attached Notice of Administrative Hearing and Mediation Rights.**

Section 409.913(12), F.S., provides exemptions from the provisions of Section 119.07(1), F.S. All information obtained pursuant to this review is confidential and exempt from the provisions of Section 119.07(1), F.S., until the Agency takes final agency action with respect to the provider and requires repayment of any overpayment or imposes an administrative sanction by Final Order.

Any questions you may have about this matter should be directed to: **Sonya Graves**, AHCA Investigator, Agency for Health Care Administration, Office of Inspector General, Medicaid Program Integrity, 2727 Mahan Drive, Mail Stop #6, Tallahassee, Florida 32308-5403, telephone **(850) 412-4596**, facsimile (850) 410-1972.

Sincerely,


Johnnie L. Shepherd
AHCA Administrator
Office of Inspector General
Medicaid Program Integrity
JS/SG/cml

Enclosure(s):

Provider Overpayment Remittance Voucher
Medical Peer Review Worksheets
Claims Analysis Spreadsheets

Copies furnished to:

Finance & Accounting
(Interoffice mail)

Health Quality Assurance
(E-mail)

NOTICE OF ADMINISTRATIVE HEARING AND MEDIATION RIGHTS

You have the right to request an administrative hearing pursuant to Sections 120.569 and 120.57, Florida Statutes. If you disagree with the facts stated in the foregoing Final Audit Report (hereinafter FAR), you may request a formal administrative hearing pursuant to Section 120.57(1), Florida Statutes. If you do not dispute the facts stated in the FAR, but believe there are additional reasons to grant the relief you seek, you may request an informal administrative hearing pursuant to Section 120.57(2), Florida Statutes. Additionally, pursuant to Section 120.573, Florida Statutes, mediation may be available if you have chosen a formal administrative hearing, as discussed more fully below.

The written request for an administrative hearing must conform to the requirements of either Rule 28-106.201(2) or Rule 28-106.301(2), Florida Administrative Code, and must be received by the Agency for Health Care Administration, by 5:00 P.M. no later than 21 days after you received the FAR. The address for filing the written request for an administrative hearing is:

Richard J. Shoop, Esquire
Agency Clerk
Agency for Health Care Administration
2727 Mahan Drive, Mail Stop # 3
Tallahassee, Florida 32308
Fax: (850) 921-0158
Phone: (850) 412-3630
E-File Website: <http://apps.ahca.myflorida.com/Efile>

Petitions for hearing filed pursuant to the administrative process of Chapter 120, Florida Statutes may be filed with the Agency by U.S. mail or courier sent to the Agency Clerk at the address listed above, by hand delivery at the address listed above, by facsimile transmission to (850) 921-0158, or by electronic filing through the Agency's website at <http://apps.ahca.myflorida.com/Efile>.

The request must be legible, on 8 ½ by 11-inch white paper, and contain:

1. Your name, address, telephone number, any Agency identifying number on the FAR, if known, and name, address, and telephone number of your representative, if any;
2. An explanation of how your substantial interests will be affected by the action described in the FAR;
3. A statement of when and how you received the FAR;
4. For a request for formal hearing, a statement of all disputed issues of material fact;
5. For a request for formal hearing, a concise statement of the ultimate facts alleged, as well as the rules and statutes which entitle you to relief;
6. For a request for formal hearing, whether you request mediation, if it is available;
7. For a request for informal hearing, what bases support an adjustment to the amount owed to the Agency; and
8. A demand for relief.

A formal hearing will be held if there are disputed issues of material fact. Additionally, mediation may be available in conjunction with a formal hearing. Mediation is a way to use a neutral third party to assist the parties in a legal or administrative proceeding to reach a settlement of their case. If you and the Agency agree to mediation, it does not mean that you give up the right to a hearing. Rather, you and the Agency will try to settle your case first with mediation.

If you request mediation, and the Agency agrees to it, you will be contacted by the Agency to set up a time for the mediation and to enter into a mediation agreement. If a mediation agreement is not reached within 10 days following the request for mediation, the matter will proceed without mediation. The mediation must be concluded within 60 days of having entered into the agreement, unless you and the Agency agree to a different time period. The mediation agreement between you and the Agency will include provisions for selecting the mediator, the allocation of costs and fees associated with the mediation, and the confidentiality of discussions and documents involved in the mediation. Mediators charge hourly fees that must be shared equally by you and the Agency.

If a written request for an administrative hearing is not timely received you will have waived your right to have the intended action reviewed pursuant to Chapter 120, Florida Statutes, and the action set forth in the FAR shall be conclusive and final.

FAR

Provider Overpayment Remittance Voucher

If you choose to make payment, please return this form along with your check.

Complete this form and send along with your check to:

Medicaid Accounts Receivable - MS # 14
Agency for Health Care Administration
2727 Mahan Drive Bldg. 2, Ste. 200
Tallahassee, FL 32308

**CHECK MUST BE MADE PAYABLE TO: FLORIDA AGENCY FOR HEALTH CARE
ADMINISTRATION**

Provider Name: MEMORIAL REGIONAL HOSPITAL
Provider ID: 010020000
MPI Case #: 11-2538-000
Overpayment Amount: \$191,418.50
Costs: \$2,553.41
Fines: \$2,500.00
Total Due: \$196,471.91
Check Number: # _____

A final order will be issued that will include the final identified overpayment, applied Sanctions, and assessed costs, taking into consideration any information or documentation that you have already submitted. Any amount due will be offset by any amount already received by the Agency in this matter.

Payment for Medicaid Program Integrity Audit



USPS Tracking™



Customer Service ›
Have questions? We're here to help.

Tracking Number: 70121010000324952540

Product & Tracking Information

Postal Product:

Extra Svc:
Certified Mail™

Available Actions

Text Updates

Email Updates

Return Receipt After Mailing

DATE & TIME	STATUS OF ITEM	LOCATION
April 17, 2015, 10:31 am	Delivered	HOLLYWOOD, FL 33025
April 17, 2015, 1:05 am	Departed USPS Facility	OPA LOCKA, FL 33054
April 16, 2015, 6:09 pm	Arrived at USPS Facility	OPA LOCKA, FL 33054
April 16, 2015, 12:45 am	Departed USPS Facility	TALLAHASSEE, FL 32301
April 16, 2015, 12:23 am	Arrived at USPS Facility	TALLAHASSEE, FL 32301
April 14, 2015, 5:11 pm	Departed Post Office	TALLAHASSEE, FL 32308
April 14, 2015, 4:09 pm	Picked Up	TALLAHASSEE, FL 32308

Track Another Package

Tracking (or receipt) number

Track It

EXHIBIT 2