

City/Town: _____ State: _____ Zip Code: _____

I attest that the information submitted above has been completed accurately, to the best of my knowledge and that failure to appropriately disclose information is reason to deny an application to be a provider with South Dakota Medicaid or terminate an existing provider agreement with South Dakota Medicaid.

Completed by: _____ Date: _____
(Signature of Authorized Official)

Printed Name: _____