

L21000449635

(Requestor's Name)

(Address)

(Address)

(City/State/Zip/Phone #)

☐ PICK-UP

☐ WAIT

☐ MAIL

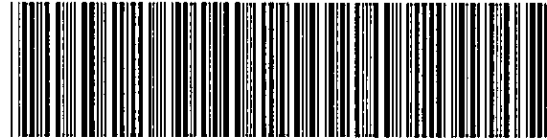
(Business Entity Name)

(Document Number)

Certified Copies \_\_\_\_\_ Certificates of Status \_\_\_\_\_

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10/12/21--01045--002 \*\*125.00

2021 OCT 12 PM 6:26  
CLERKING UNIT

OCT 1 2021

**COVER LETTER**

**TO: New Filing Section  
Division of Corporations**

**SUBJECT:** MDR Hospital Services, LLC  
\_\_\_\_\_  
Name of Limited Liability Company

The enclosed Articles of Organization and fee(s) are submitted for filing.

Please return all correspondence concerning this matter to the following:

Mr. John Anderson

\_\_\_\_\_  
Name of Person

MDR Hospital Services, LLC

\_\_\_\_\_  
Firm/Company

13825 ICOT Blvd. Suite 611

\_\_\_\_\_  
Address

Clearwater, FL 33762

\_\_\_\_\_  
City/State and Zip Code

john@medicaiddoneright.com

\_\_\_\_\_  
E-mail address: (to be used for future annual report notification)

For further information concerning this matter, please call:

Larry Rayburn

813

334-5077

at (\_\_\_\_\_) \_\_\_\_\_

Name of Person

Area Code

Daytime Telephone Number

Enclosed is a check for the following amount:

☒ \$125.00 Filing Fee

☐ \$130.00 Filing Fee &  
Certificate of Status

☐ \$155.00 Filing Fee &  
Certified Copy  
(additional copy is enclosed)

☒ \$160.00 Filing Fee,  
Certificate of Status &  
Certified Copy  
(additional copy is enclosed)

**Mailing Address**

New Filing Section  
Division of Corporations  
P.O. Box 6327  
Tallahassee, FL 32314

**Street Address**

New Filing Section Division  
The Centre of Tallahassee  
2415 N. Monroe Street, Suite 810  
Tallahassee, FL 32303

ARTICLES OF ORGANIZATION FOR FLORIDA LIMITED LIABILITY COMPANY

ARTICLE I - Name:

The name of the Limited Liability Company is:

MDR Hospital Services, LLC

(Must contain the words "Limited Liability Company," "LLC," or "L.L.C.")

ARTICLE II - Address:

The mailing address and street address of the principal office of the Limited Liability Company is:

Principal Office Address:

Mailing Address:

13825 ICOT Blvd, Suite 611

Clearwater, FL 33762

13825 ICOT Blvd, Suite 611

Clearwater, FL 33762

ARTICLE III - Registered Agent, Registered Office, & Registered Agent's Signature:

(The Limited Liability Company cannot serve as its own Registered Agent. You must designate an individual or another business entity with an active Florida registration.)

The name and the Florida street address of the registered agent are:

Cindy Prevost

Name

13825 ICOT Blvd, Suite 611

Florida street address (P.O. Box **NOT** acceptable)

Clearwater

FL

33762

City

State

Zip

*Having been named as registered agent and to accept service of process for the above stated limited liability company at the place designated in this certificate, I hereby accept the appointment as registered agent and agree to act in this capacity. I further agree to comply with the provisions of all statutes relating to the proper and complete performance of my duties, and I am familiar with and accept the obligations of my position as registered agent as provided for in Chapter 605, F.S..*

  
Registered Agent's Signature (REQUIRED)

(CONTINUED)

2010 OCT 12 PM 6:00  
FILED

**ARTICLE IV-**

The name and address of each person authorized to manage and control the Limited Liability Company:

**Title:**

"AMBR" = Authorized Member

"MGR" = Manager

**Name and Address:**

AMBR

Medicaid Done Right, LLC  
13825 ICOT Blvd, Suite 611  
Clearwater, FL 33762

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(Use attachment if necessary)

**ARTICLE V:** Effective date, if other than the date of filing: \_\_\_\_\_. (OPTIONAL)

(If an effective date is listed, the date must be specific and cannot be more than five business days prior to or 90 days after the date of filing.)

**Note:** If the date inserted in this block does not meet the applicable statutory filing requirements, this date will not be listed as the document's effective date on the Department of State's records.

**ARTICLE VI:** Other provisions, if any.

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

**REQUIRED SIGNATURE:**



**Signature of a member or an authorized representative of a member.**

This document is executed in accordance with section 605.0203 (1) (b), Florida Statutes.  
I am aware that any false information submitted in a document to the Department of State  
constitutes a third degree felony as provided for in s.817.155, F.S.

John Anderson, as CEO of Medicaid Done Right, LLC

Typed or printed name of signee

**Filing Fees:**

\$125.00 Filing Fee for Articles of Organization and Designation of Registered Agent

\$ 30.00 Certified Copy (Optional)

\$ 5.00 Certificate of Status (Optional)