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(Address)

(Address)

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Account#: I20000000088

Date: **May 15, 2023**

Name: **Claudia Camilus**

Reference #: **2000890**

Entity Name: **MEDICAID PRACTICE SYSTEMS, LLC**

- [x] Articles of Incorporation/Authorization to Transact Business
- [ ] Amendment
- [ ] Change of Agent
- [ ] Reinstatement
- [ ] Conversion
- [ ] Merger
- [ ] Dissolution/Withdrawal
- [ ] Fictitous Name
- [x] Other **Certify Copy**

Authorized Amount: $ 155.00

Signature:

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Date: May 15, 2023

Name: Claudia Camilus

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Entity Name: MEDICAID PRACTICE SYSTEMS, LLC

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- [ ] Dissolution/Withdrawal
- [ ] Fictitous Name
- [x] Other **Certify Copy**

Authorized Amount: $ 155.00

Signature: [signature]

APPLICATION BY FOREIGN LIMITED LIABILITY COMPANY FOR AUTHORIZATION TO TRANSACT BUSINESS IN FLORIDA

IN COMPLIANCE WITH SECTION 605.0902, FLORIDA STATUTES, THE FOLLOWING IS SUBMITTED TO REGISTER A FOREIGN LIMITED LIABILITY COMPANY TO TRANSACT BUSINESS IN THE STATE OF FLORIDA:

1. Medicaid Practice Systems, LLC
(Name of Foreign Limited Liability Company; must include "Limited Liability Company," "L.L.C.," or "LLC.")

(If name unavailable, enter alternate name adopted for the purpose of transacting business in Florida. The alternate name must include "Limited Liability Company," "L.L.C." or "LLC.")

2. Delaware
(Jurisdiction under the law of which foreign limited liability company is organized)

3. _____
(FEI number, if applicable)

4. _____
(Date first transacted business in Florida, if prior to registration.)
(See sections 605.0904 & 605.0905, F.S. to determine penalty liability)

5. 6240 Shirley Street, Suite 105
(Street Address of Principal Office)

Naples, FL 34109

6. 6240 Shirley Street, Suite 105
(Mailing Address)

Naples, FL 34109

7. Name and street address of Florida registered agent: (P.O. Box NOT acceptable)

Name: Louis R. Gigliotti, Jr.

Office Address: 6240 Shirley Street, Suite 105

Naples (City), Florida 34109 (Zip code)

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TALLAHASSEE, FL

Registered agent's acceptance:
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 application, 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 relative to the proper and complete performance of my duties, and I am familiar with and accept the obligations of my position as registered agent.

_____
(Registered agent's signature)

8. For initial indexing purposes, list names, title or capacity and addresses of the primary members/managers or persons authorized to manage [up to six (6) total]:

Title or Capacity:	Name and Address:	Title or Capacity:	Name and Address:
☒Manager	Name: MPS Software Solutions, LLC	☐Manager	Name: Sherrill Family Trust dated March 28, 2013
☐Member	Address: 6240 Shirley St, Ste 105	☒Member	Address: 6240 Shirley St, Ste 105
☐Authorized	Naples, FL 34109	☐Authorized	Naples, FL 34109
Person		Person	
☐Other	☐Other	☐Other	☐Other
☐Manager	Name:	☐Manager	Name:
☐Member	Address:	☐Member	Address:
☐Authorized		☐Authorized	
Person		Person	
☐Other	☐Other	☐Other	☐Other
☐Manager	Name:	☐Manager	Name:
☐Member	Address:	☐Member	Address:
☐Authorized		☐Authorized	
Person		Person	
☐Other	☐Other	☐Other	☐Other

Important Notice: Use an attachment to report more than six (6). The attachment will be imaged for reporting purposes only. Non-indexed individuals may be added to the index when filing your Florida Department of State Annual Report form.

9. Attached is a certificate of existence, no more than 90 days old, duly authenticated by the official having custody of records in the jurisdiction under the law of which it is organized. (If the certificate is in a foreign language, a translation of the certificate under oath of the translator must be submitted)

10. 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.

Signature of an authorized person

Louis R. Gigliotti, Jr.

Typed or printed name of signee

Delaware

The First State

I, JEFFREY W. BULLOCK, SECRETARY OF STATE OF THE STATE OF DELAWARE, DO HEREBY CERTIFY "MEDICAID PRACTICE SYSTEMS, LLC" IS DULY FORMED UNDER THE LAWS OF THE STATE OF DELAWARE AND IS IN GOOD STANDING AND HAS A LEGAL EXISTENCE SO FAR AS THE RECORDS OF THIS OFFICE SHOW, AS OF THE FIFTEENTH DAY OF MAY, A.D. 2023.

AND I DO HEREBY FURTHER CERTIFY THAT THE SAID "MEDICAID PRACTICE SYSTEMS, LLC" WAS FORMED ON THE TWENTY-SEVENTH DAY OF MARCH, A.D. 2002.

AND I DO HEREBY FURTHER CERTIFY THAT THE ANNUAL TAXES HAVE BEEN PAID TO DATE.

Jeffrey W. Bullock, Secretary of State

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