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Date: **May 15, 2023**

Account#: 120000000088

Name: **Claudia Camilus**

Reference #: **2000890**

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

☒ Articles of Incorporation/Authorization to Transact Business

☐ Amendment

☐ Change of Agent

☐ Reinstatement

☐ Conversion

☐ Merger

☐ Dissolution/Withdrawal

☐ Fictitious Name

☒ Other **Certify Copy**

Authorized Amount: **\$ 155.00**

Signature: 



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Signature: 

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

IN COMPLIANCE WITH SECTION 405.002, 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 3. _____
(Jurisdiction under the law of which foreign limited liability company is organized) (FID number, if applicable)

4. _____
(Date first transacted business in Florida, if prior to registration.)
(See sections 405.0904 & 605.0903, F.S. to determine penalty liability)

5. 6240 Shirley Street, Suite 105 6. 6240 Shirley Street, Suite 105
(Street Address of Principal Office) (Mailing Address)

Naples, FL 34109 Naples, FL 34109

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

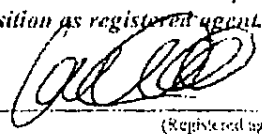
Name: Louis R. Gigliotti, Jr.

Office Address: 6240 Shirley Street, Suite 105

Naples, Florida 34109
(City) (Zip code)

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)

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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]:

<u>Title or Capacity:</u>	<u>Name and Address:</u>	<u>Title or Capacity:</u>	<u>Name and Address:</u>
<input checked="" type="checkbox"/> Manager	Name: <u>MPS Software Solutions, LLC</u>	<input type="checkbox"/> Manager	Name: <u>Sherrill Family Trust dated March 28, 2013</u>
<input type="checkbox"/> Member	Address: <u>6240 Shirley St, Ste 105</u>	<input checked="" type="checkbox"/> Member	Address: <u>6240 Shirley St, Ste 105</u>
<input type="checkbox"/> Authorized	<u>Naples, FL 34109</u>	<input type="checkbox"/> Authorized	<u>Naples, FL 34109</u>
Person	_____	Person	_____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
 <input type="checkbox"/> Manager	Name: _____	 <input type="checkbox"/> Manager	Name: _____
<input type="checkbox"/> Member	Address: _____	<input type="checkbox"/> Member	Address: _____
<input type="checkbox"/> Authorized	_____	<input type="checkbox"/> Authorized	_____
Person	_____	Person	_____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____
 <input type="checkbox"/> Manager	Name: _____	 <input type="checkbox"/> Manager	Name: _____
<input type="checkbox"/> Member	Address: _____	<input type="checkbox"/> Member	Address: _____
<input type="checkbox"/> Authorized	_____	<input type="checkbox"/> Authorized	_____
Person	_____	Person	_____
<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> Other _____	<input type="checkbox"/> 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 signer

Delaware

The First State


Page 1

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