

**2020 FLORIDA LIMITED LIABILITY COMPANY ANNUAL REPORT**

DOCUMENT# L17000092218

**FILED**  
**Jan 29, 2020**  
**Secretary of State**  
**5463595829CC**

**Entity Name:** GLYCARE BILLING AND MANAGEMENT LLC

**Current Principal Place of Business:**

4190 BELFORT ROAD  
SUITE 352  
JACKSONVILLE, FL 32216

**Current Mailing Address:**

4190 BELFORT ROAD STE 352  
JACKSONVILLE, FL 32216 US

**FEI Number:** 82-1307545

**Certificate of Status Desired:** No

**Name and Address of Current Registered Agent:**

DIABETES MANAGEMENT PARTNERS, LLC DBA GLYCARE  
4190 BELFORT ROAD STE 352  
JACKSONVILLE, FL 32216 US

*The above named entity submits this statement for the purpose of changing its registered office or registered agent, or both, in the State of Florida.*

**SIGNATURE:** CORLEENE VAVERKA

01/29/2020

Electronic Signature of Registered Agent

Date

**Authorized Person(s) Detail :**

Title AMBR  
Name MOONEY, KYLE  
Address 4190 BELFORT ROAD STE 352  
City-State-Zip: JACKSONVILLE FL 32216

Title AMBR  
Name EVANS, JOHN  
Address 4190 BELFORT ROAD STE 352  
City-State-Zip: JACKSONVILLE FL 32216

Title AMBR  
Name SUTTON, DAVID  
Address 4190 BELFORT ROAD STE 352  
City-State-Zip: JACKSONVILLE FL 32216

Title AUTHORIZED MEMBER  
Name VAVERKA, CORLEENE  
Address 4190 BELFORT RD.  
SUITE 352  
City-State-Zip: JACKSONVILLE FL 32216

*I hereby certify that the information indicated on this report or supplemental report is true and accurate and that my electronic signature shall have the same legal effect as if made under oath; that I am a managing member or manager of the limited liability company or the receiver or trustee empowered to execute this report as required by Chapter 605, Florida Statutes; and that my name appears above, or on an attachment with all other like empowered.*

**SIGNATURE:** CORLEENE VAVERKA

DIR OF OPERATIONS

01/29/2020

Electronic Signature of Signing Authorized Person(s) Detail

Date