MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT AND COMPLIANCE UNIT

PROVIDER UPDATE REQUEST

A separate form must be submitted for each provider type and/or individual/group. Sections I and II MUST be completed and the form must be signed. Include the effective date where indicated. Failure to follow these instructions could result in the denial of your request.

SECTION I: PROVIDER INFORMATION – Fill in applicable fields with provider's current information.

FOR **INDIVIDUAL'S** ONLY: LAST NAME	FIRST NAME	MIDDLE INITIAL	SUFFIX

FOR **AGENCIES** ONLY: PROVIDER NAME	DBA (if applicable)
NATIONAL PROVIDER IDENTIFIER (NPI)	TAXONOMY CODE

SECTION II: CONTACT PERSON – Person that can discuss the requested change and where notification can be sent to.

NAME	TELEPHONE	E-MAIL ADDRESS

SECTION III: CHANGE REQUEST - Place an "X" in the box next to the change(s) requested. Fill in applicable fields with the new information. All required documents, as indicated by the change requested, must be submitted or the request will be denied. Attach additional sheets as necessary.

☐ MAIN PHYSICAL LOCATION ☐ DELETE ☐ EDIT EFFECTIVE:
ADDRESS CITY STATE ZIP CODE

☐ MAILING/REMITTANCE ADDRESS ☐ DELETE ☐ EDIT EFFECTIVE:
ADDRESS CITY STATE ZIP CODE

☐ ADDITIONAL PRACTICE LOCATION ☐ ADD ☐ DELETE ☐ EDIT EFFECTIVE:
ADDRESS CITY STATE ZIP CODE

TELEPHONE NUMBER COUNTY

☐ ADDITIONAL PRACTICE LOCATION ☐ ADD ☐ DELETE ☐ EDIT EFFECTIVE:
ADDRESS CITY STATE ZIP CODE

TELEPHONE NUMBER COUNTY

☐ ADD INDIVIDUAL INDICATED IN SECTION I ABOVE TO THE FOLLOWING GROUP/CLINIC PRACTICE LOCATION
NAME: NPI: EFFECTIVE:
ADDRESS/CITY/STATE/ZIP CODE:

☐ REMOVE INDIVIDUAL INDICATED IN SECTION I ABOVE FROM THE FOLLOWING GROUP/CLINIC PRACTICE LOCATION
NAME: NPI: EFFECTIVE:
ADDRESS/CITY/STATE/ZIP CODE:

☐ BUSINESS TELEPHONE NUMBER:

☐ BUSINESS FAX NUMBER:

☐ BUSINESS E-MAIL ADDRESS:

☐ INDIVIDUAL NAME:
- Attach a copy of the individual's license issued in the new name.

☐ MEDICARE NUMBER:
- Attach notification from CMS.

☐ ADVANCED PRACTICE NURSE/NURSE MIDWIFE MEDICATION PRESCRIBER
- Attach a copy of the collaborative practice agreement.

☐ PROVISIONALLY LICENSED PROFESSIONAL COUNSELOR TO LICENSED PROFESSIONAL COUNSELOR
- Attach a copy of the license.

☐ LICENSE EXPIRATION DATE
- Attach a copy of the license.

☐ VOLUNTARILY TERMINATE MEDICAID ENROLLMENT EFFECTIVE:

☐ CLIA Certificate
- Attach certificate

CHANGE DIRECT DEPOSIT PAY TO INFORMATION (Submit **only** if the Electronic Fund Transfer – Online form has already been e-mailed.)

☐ Payee Name.
Payee Address:
Payee Taxpayer Identification Number:

AGENCY NAME ONLY (Federal Tax ID and NPI Remains the Same):
EFFECTIVE:

☐
- Explain in detail in Section IV below the reason for the change.
- Attach a pre-printed copy of an IRS notification that includes the new name and Federal Tax ID. A W-9 is not acceptable.
- Attach proof of registration of the name with the Missouri Secretary of State (excluding out-of-state providers).

FEDERAL TAX ID ONLY (Agency Name and NPI Remains the Same):
EFFECTIVE:

☐
- Explain in detail in Section IV below the reason for the change.
- Attach a pre-printed copy of an IRS notification that includes the new name and Federal Tax ID. A W-9 is not acceptable.

☐ FICTITIOUS or DOING BUSINESS AS (DBA) NAME:
- Attach Registration of Fictitious Name filed with the Missouri Secretary of State (excluding out-of-state providers).

☐ CORPORATION CHANGE OF STOCKHOLDERS
- Submit a list of stockholders and the percentage of stock held by each.

☐ SALE OF ASSETS OR, IF PROVIDER IS A SOLE PROPRIETOR, CHANGE OF OWNERSHIP
The Agency Name, NPI and Federal Tax ID Remains the Same
EFFECTIVE:
- The buying entity must be currently enrolled with Missouri Medicaid.

BUYING PROVIDER NAME	NPI NUMBER

☐ OTHER
- Clearly explain the requested change and attach any necessary documentation.

SECTION IV: COMMENTS/ADDITIONAL INFORMATION/OTHER

PROVIDER OR INDIVIDUAL NAME FROM SECTION I	NPI NUMBER

THE AUTHORIZED SIGNER OF THIS DOCUMENT VERIFIES THAT HE/SHE IS AN INDIVIDUAL OR THE REPRESENTATIVE OF THE PROVIDER AND IS THE DULY AUTHORIZED AGENT TO EXECUTE THIS CHANGE REQUEST DOCUMENT ON BEHALF OF THE PROVIDER UNDER AUTHORITY GRANTED BY SAID PROVIDER.

(Signature or Typed Named)	DATE

TYPE OR PRINT NAME OF PERSON SIGNING	TYPE OR PRINT TITLE OF PERSON SIGNING

FAX COMPLETED FORM AND ANY REQUIRED DOCUMENTS TO

573/634-3105

MMAC PROVIDER ENROLLMENT USE ONLY

☐ The following information must be submitted in order to process the requested change. Fax this form and the additional information to 573/751-5065, attention Clerk _____. Failure to submit to this fax number and to the attention of Clerk _____ will delay the processing of the request or could result in the denial of the request(s).

The requested change(s) has been: ☐ PROCESSED ☐ DENIED

REASON FOR DENIAL

PROCESSED BY	DATE
CLERK	