



**STATE OF MISSOURI  
DEPARTMENT OF SOCIAL SERVICES  
MISSOURI MEDICAID AUDIT AND COMPLIANCE  
HCBS VOLUNTARY TERMINATION REQUEST**

**SECTION 1: PROVIDER INFORMATION – COMPLETE ALL APPLICABLE FIELDS IN A LEGIBLE MANNER. Please complete ONE form per provider EIN. THIS IS A REQUIRED SECTION.**

LEGAL AGENCY NAME AS IT APPEARS WITH THE IRS:			DOING BUSINESS AS NAME (IF APPLICABLE):		
NPI:			SSBG (optional):		
<input type="checkbox"/> CDS	<input type="checkbox"/> In-Home	<input type="checkbox"/> Reassessments	<input type="checkbox"/> Adult Daycare	<input type="checkbox"/> RCF (Residential Care)	<input type="checkbox"/> ALF (Assisted Living)

EMAIL ADDRESS FOR CONFIRMATION OF CHANGES:

**SECTION 2: VOLUNTARILY TERMINATE ENROLLMENT – Effective Date Must Be Consistent On All Documents Submitted.**

**THE FOLLOWING MUST BE ATTACHED – USE THE CHECKBOXES TO CHECK OF DOCUMENTS:**

- A letter stating that you wish to terminate your enrollment with MO HealthNet – include your NPI and effective date in the letter.
- A copy of the letter that you sent to the Department of Health and Senior Services letting them know the effective date you will be terminating your enrollment with MO HealthNet.
- A copy of the letter that was sent to the participants letting them know the effective date you will be terminating your enrollment and that they will need to find a new provider.
- List of Medicaid Participant DCNs serviced by your entity.

**I WISH TO VOLUNTARILY TERMINATE MY ENROLLMENT WITH MOHEALTHNET EFFECTIVE - LIST MM/DD/YYYY IN BLANK BELOW. DATE MUST BE LISTED ON BLANK TO PROCESS CORRECTLY.  
EFFECTIVE (MM/DD/YYYY): \_\_\_\_\_**

**Location where records will be stored for 5 years after the date of termination listed above:**

ADDRESS:	CITY:	STATE:	ZIP:
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Future contact person name:

Future contact phone:

Future contact e-mail:

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

(Original Signature) <b>Electronic signature is not acceptable.</b>	Date:
TYPE OR PRINT NAME OF AUTHORIZED PERSON SIGNING:	TYPE OR PRINT TITLE OF AUTHORIZED SIGNER:

**PLEASE FAX FORM & ALL DOCUMENTS TO 573-634-3105. DO NOT EMAIL FORM Unless Instructed.  
ALL OF THE REQUIRED DOCUMENTATION MUST BE SUBMITTED TO PROCESS YOUR REQUEST.**

**MISSOURI MEDICAID AUDIT AND COMPLIANCE USE ONLY BELOW:**

<input type="checkbox"/> APPROVED	<input type="checkbox"/> REJECTED
SENT TO: <input type="checkbox"/> DHSS <input type="checkbox"/> Terminations <input type="checkbox"/> Others (as needed)	
MMAC STAFF ID/SIGNATURE:	DATE: