MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT & COMPLIANCE

LONG TERM CARE PHARMACY DISPENSING FEE PROVIDFER SPECIALTY APPLICATION

Provider Information

Provider NPI:	**Provider Taxonomy code:**

Pharmacy Name

Pharmacy Address:

Business phone number:	**Business Fax number:**

Application

*Facilities for whom you dispense in unit dose or controlled dose drug distribution system. Facility name (s): **Facility Name**	*Type of unit dose or controlled dose drug distribution system dispensed in each facility **Drug System for that facility**

By my signature, I hereby certify that I provide the required distribution system as stated above, and that I provide emergency services and 24 hours a day, sever (7) days a week availability to the long term care facility. In addition, I am able and willing to assist the facility and its residents in accessing medications through the MO HealthNet exception process

Signature of Authorized Personnel:	**Date signed:**
Name of Authorized Personnel:	**Title:**

Submit this form via Fax to: 573-634-3105
Attn: Provider Enrollment Unit
Missouri Medicaid Audit & Compliance

Questions regarding this form should be submitted to MMAC.Providerenrollment@dss.mo.gov