MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT AND COMPLIANCE UNIT
PROVIDER UPDATE REQUEST

This form should be completed when a MO HealthNet provider needs to update their MO HealthNet enrollment file. Refer to Provider Updates for a list of circumstances that require the completion of this form. The following guidelines must be followed:

- **You MUST complete Sections 1 and 2 and the form must be signed.**
- Submit a separate form for each provider type and/or individual/group.
- Include the effective date where indicated.
- Section 6 can be used for additional comments for any of the sections completed.
- All 3 pages of the form must be submitted.
- **Failure to follow these instructions could result in the denial of your request.**

Submit completed form by fax to 573-634-3105.

Section 1: Provider Information - Required

Choose One: ☐ Individual Provider ☐ Group Provider	Individual/Group National Provider Identifier (NPI)

Individual Provider	Last Name	First Name	Middle Initial	Suffix
Group Provider	Legal Business Name as Registered with Internal Revenue Service (IRS)			
	Doing Business As (DBA) (if applicable)		Taxonomy Code	

Section 2: Contact Person for Requested Change - Required

Name	Phone Number	Email Address

Section 3: Main Address Change – Complete this section if the provider's main practice location/remittance address is changing

- For **individual providers** updating the main practice location or remittance (pay to) address, the individual provider must sign the form.
- For **group providers** updating the main practice location or remittance (pay to) address, the authorized personnel listed with MMAC must sign the form.
- If the main location and/or the Remittance/Pay to location NPI belongs to an individual or a group that is not enrolled with MMAC then the provider must submit the Enrollment Application for the individual provider.

Main Physical Practice Location – Choose One: ☐ Change Address ☐ Edit Address ☐ Delete Address		Effective Date	End date (if applicable)	
Street Address		City	State	Zip Code
Business Phone number	Business Fax		County	
Business Email Address			Group NPI (If applicable)	

Remittance/Pay To Location* - Choose One: ☐ Change Address ☐ Edit Address ☐ Delete Address		Effective Date	End date (if applicable)	
Street Address		City	State	Zip Code
Business Phone	Business Fax		County	
Business Email Address			Group NPI (If applicable)	

Section 4: Additional Practice Location(s) – Complete this section if the provider's additional practice location is changing

Most providers can update their additional practice address in eMOMED. Only use this section if you have attempted to update the location in eMOMED and received a message that you must complete this form. If necessary, list additional locations on a separate sheet.

Additional Practice Location – Choose One: ☐ Add ☐Change ☐ Edit ☐ Delete	Effective Date	End Date (If applicable)	
Street Address	City	State	Zip code
Business Phone number	Business Fax	County	
Business Email Address		Group NPI (If applicable)	

Section 5: Licensure and Name Change

Choose One:

☐ Change from Provisionally Licensed Professional Counselor to Licensed Professional Counselor – Attach copy of license

☐ License Expiration Date – Attach copy of license

☐ Individual Name Change – Attach copy of license issued in new name and complete previous and new name below

Previous Name	New Name

Section 6: Additional Updates – Complete if any of the below apply

☐	Add Medicare Number	Medicare Number:	Effective Date:
☐	Add Clinical Laboratory Improvement Amendments (CLIA) Number – Attach copy of CLIA Certificate		CLIA Number:
☐	Add taxonomy code		Taxonomy Code(s):

☐ Enrollment Backdate Request – *Required fields below

Retroactive date may not be prior to the issue date of the provider's required documents for enrollment with MO HealthNet. Enrollment cannot be backdated more than one year from the date of service and the date of the request submission

MO HealthNet Participant Name*	Participant MO HealthNet ID Number*
Date Requested*	Date of Service*

☐	Add specialty code For a list of specialties and their codes, review the Provider Specialty Tables Manual.	Specialty Code	Effective Date:

☐ Add Advance Practice Nurse/Nurse Midwife Medication Prescriber (28 specialty code)

Attach copy of Collaborative Practice Agreement (CPA). All addresses on file MUST be listed on the CPA. The CPA must be attached to process the request, any additional locations must be listed on Nurse-Additional Practice Locations List

☐ Remove Individual from Practice - Removing an individual from a location does not terminate their MO HealthNet enrollment

Name of Individual to Remove	Group NPI	Effective Date

☐ Switch from Ordering, Prescribing, and Referring [OPR] enrollment to Fee For Service [FFS]

Only applicable if the provider has submitted an OPR application in 2024 or afterwards

Practice Street Address	City	State	Zip code
Group Name	**Group NPI**	**Effective Date**	

☐ **OTHER**: Use Section 8 of this form to describe the change. Include any supporting documents.

Section 7: Organizational Changes – Complete if the Provider Information Changed but Ownership Did Not Change

☐ Add/Remove a fictitious name (DBA) – **Choose One:** ☐ **Add** ☐ **Remove** ☐ **Change/Update**

Attach the following:

- Current Secretary of State fictious name registration
- Current copy of licensure listing the DBA name (if applicable)
- Documentation from CMS NPPES with NPI information for the DBA name.
- Business Organization Structure (BOS) and all necessary documents required on this form, listing all managing employees and owners with full name, Social Security Number (SSN) and date of birth. For instructions on how to complete the BOS form, refer to BOS instructions.

DBA Name

☐ Managing Employees: ☐Add ☐Remove

NOTE: If the provider is required to be enrolled with Medicare the provider must update this information with Medicare first.
If updating more than one individual, you can submit a separate sheet with the individual's information.

Managing Employee Name	Title		
Social Security Number	**Date of Birth**		
Street Address	**City**	**State**	**Zip code**

Section 8: Notes

Use this section for notes regarding any of the prior sections. Be descriptive.

Authorized Signature - Required

The authorized signer of this request verifies that they are an individual or the representative of the provider and is the duly authorized agent to execute this change request on behalf of this provider under authority granted by said provider.

MMAC only accept authorized signers with either an ink signature or an approved electronic signature.

Submit completed form by fax to 573-634-3105.

Signature	Date
Typed/Print Name	**Title**

MMAC Provider Enrollment Use Only

Change: ☐ Processed ☐ Rejected	MMAC Employee Name	Date

MMAC Comments