



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. ***IHS, CDS, RCF, ALF, ADC & 27 must utilize HCBS change Request form.**

- **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: <input type="checkbox"/> Individual Provider <input type="checkbox"/> Group Provider	Individual/Group National Provider Identifier (NPI)
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Individual Provider	Last Name	First Name	Middle Initial	Suffix
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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
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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: <input type="checkbox"/> Change Address <input type="checkbox"/> Edit Address <input type="checkbox"/> 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: <input type="checkbox"/> Change Address <input type="checkbox"/> Edit Address <input type="checkbox"/> 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: <input type="checkbox"/> Add <input type="checkbox"/> Change <input type="checkbox"/> Edit <input type="checkbox"/> 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
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Section 6: Additional Updates – Complete if any of the below apply

<input type="checkbox"/>	Add Medicare Number	Medicare Number:	Effective Date:	
<input type="checkbox"/>	Add Clinical Laboratory Improvement Amendments (CLIA) Number – Attach copy of CLIA Certificate	CLIA Number:		
<input type="checkbox"/>	Add taxonomy code	Taxonomy Code(s):		
<input type="checkbox"/>	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*		
<input type="checkbox"/>	Add specialty code For a list of specialties and their codes, review the Provider Specialty Tables Manual .	Specialty Code	Effective Date:	
<input type="checkbox"/>	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			
<input type="checkbox"/>	Remove Individual from Practice - Removing an individual from a location does not <u>terminate</u> their MO HealthNet enrollment			
	Name of Individual to Remove	Group NPI	Effective Date	
<input type="checkbox"/>	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	
<input type="checkbox"/>	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

<input type="checkbox"/>	Add/Remove a fictitious name (DBA) – Choose One: <input type="checkbox"/> Add <input type="checkbox"/> Remove <input type="checkbox"/> Change/Update			
	Attach the following:			
	<ul style="list-style-type: none"> • Current Secretary of State fictitious 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			
<input type="checkbox"/>	Managing Employees: <input type="checkbox"/> Add <input type="checkbox"/> 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: <input type="checkbox"/> Processed <input type="checkbox"/> Rejected	MMAC Employee Name	Date
MMAC Comments		