MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT & COMPLIANCE

MO HEALTHNET PROVIDER ENROLLMENT APPLICATION (OPR)

COMPLETING THIS APPLICATION AS AN INDIVIDUAL PROVIDER, YOU SHOULD ANSWER THE QUESTIONS FOR YOURSELF IF THE ANSWER IS YES TO ANY OF THESE QUESTIONS, AN EXPLANATION, DATE, STATE, CITY AND COUNTY, MUST BE COMPLETED. INCLUDE ADDITIONAL SHEETS AND/OR ATTACHMENTS IF NECESSARY.

1. Has the applying provider, any managing employee, or any person having an ownership or control interest; ever been personally terminated, denied enrollment, suspended, restricted by agreement, or otherwise sanctioned by Medicare, Medicaid, MO HealthNet, or ANY state or federal programs in ANY state? Yes ☐ No ☐
Incidents where notice of program deficiency resulted in voluntary withdrawal must be included.

2 . Has the applying provider, any managing employee, or any person having an ownership or control interest for the applying provider; ever had ownership, indirect ownership, controlling interest, or been administrator of a facility or agency that has been terminated, denied enrollment, suspended, restricted by agreement, other otherwise sanctioned by Medicare, Medicaid, MO HealthNet or ANY state or federal programs in ANY state? Yes ☐ No ☐
Incidents where notice of program deficiency resulted in voluntary withdrawal must be included.

3. Has the license of the applying provider, any managing employee, or any person having an ownership or control interest; ever been revoked, suspended, surrendered, or in any way restricted by probation or agreement by ANY licensing authority in ANY state? Yes ☐ No ☐
If yes, explain:

4. Does the applying provider, any managing employee, or any person having an ownership or control interest; have any outstanding criminal fines, restitution orders, or overpayments pertaining to health care in Missouri or ANY other state? Yes ☐ No ☐
If yes, explain:

5. Has the applying provider, any managing employee, or any person having an ownership or control interest; ever been convicted of a crime, excluding minor traffic citations? Yes ☐ No ☐
If yes, list conviction(s), when, and where:

6. Are there any criminal proceedings, restitution orders, or overpayments currently pending for the applying provider, any managing employee, or any person having an ownership or control interest; or any individual involved with the applying provider's clinic, group, corporation or any other association? Yes ☐ No ☐
If yes, list pending changes and location:

7. Is the applying provider, any managing employee, or any person having an ownership or control interest; related, including but not limited to, a spouse, parent, child, sibling, etc., to any owner, officer, agent, managing employee, director or shareholder that has been convicted of a crime health care services? Yes ☐ No ☐
If yes, list conviction, date and location:

8. Does the applying provider have any pending enrollment applications with any other state or federal program, other than this application? Yes ☐ No ☐
If yes, list state and program:

9. Does the applying provider, any managing employee, or any person having an ownership or control interest; have any pending complaint investigations being reviewed by any professional boards? Yes ☐ No ☐
If yes, explain:

10. Does the applying provider, any managing employee, or any person having ownership or control interest; or any individual involved with the applying provider's practice, clinic, group, corporation or any other association, have any outstanding overpayments to Medicare, Medicaid, or any other federal/state health care programs?
Yes ☐ No ☐ If yes, explain:

11. Does the applying provider now hold a certificate to dispense controlled substances from the federal Drug Enforcement Agency (DEA), the Missouri Bureau of Narcotics and Dangerous Drugs (BNDD), or any other state?
Yes ☐ No ☐ If yes, list all states, certificate numbers, AND #15 MUST BE COMPLETED.

DEA Number: BNDD Number:
DEA Number: BNDD Number:

12. Has the DEA or BNDD certificate ever been suspended, revoked, surrendered, or in any way restricted by probation or agreement? Yes ☐ No ☐
If yes, explain with date, state, city, county, and included attachments.

☐ By checking this block, I certify that I have reviewed the federal and state disclosure regulations for all applying Medicaid providers which are attached to this enrollment application. I also certify that all individuals and/or business organizations with direct or indirect ownership, management and/or control interests have been fully disclosed.

To the best of my knowledge, the information supplied on this application is accurate, complete and is hereby released to the Missouri Department of Social Services. I also understand that pursuant to 13 CSR 65-2, I must advise the Department, in writing, of any changes affecting the provider's enrollment record.

Signature of Applying Provider:	**Date signed:**
Name of Applying Provider:	**Title:**

Please fax your completed application and any supporting documentation to our automated fax system: 573-634-3105

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