



DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT & COMPLIANCE
MISSOURI MEDICAID PERSONAL CARE PROVIDER QUESTIONNAIRE FOR RCF & ALF

**PLEASE TYPE OR PRINT ALL FORMS IN BLACK INK
ANSWERS ARE REQUIRED FOR ALL QUESTIONS – USE “N/A” OR “NONE” IF APPLICABLE**

PROVIDER AGENCY LEGAL NAME, AS REGISTERED WITH THE IRS AND MO SECRETARY OF STATE

PROVIDER AGENCY DOING BUSINESS AS (DBA) NAME, AS REGISTERED WITH MO SECRETARY OF STATE (if applicable)

PROVIDER FULL PHYSICAL ADDRESS

COUNTY

PROVIDER FULL MAILING ADDRESS (for correspondence, remittance advices and tax forms)

NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER

BUSINESS E-MAIL ADDRESS

FEDERAL EMPLOYER IDENTIFICATION NUMBER (EIN) FROM IRS

BUSINESS TELEPHONE NUMBER WITH AREA CODE

FACILITY LICENSE NUMBER (**RCF ONLY**) – ATTACH A COPY OF LICENSE

BUSINESS FAX NUMBER WITH AREA CODE

NAME OF ADMINISTRATOR

CIRCLE SPECIALTY CODE(S) TO BE ASSIGNED

76 – PERSONAL CARE CLINIC

CHECK TYPE OF PRACTICE

INDIVIDUAL PRACTICE ☐

PARTNERSHIP ☐

CORPORATION (INC, LLC) ☐

CHARTABLE ☐

PRIVATELY OWNED ☐

CITY, MUNICIPAL, COUNTY, DISTRICT, OR STATE OWNED ☐

SUBMIT THIS FORM WITH REST OF ENROLLMENT PACKET TO:

MISSOURI MEDICAID AUDIT & COMPLIANCE
ATTN: CONTRACTS UNIT
3418 Knipp Drive, Suite F
Jefferson City, MO 65109

Any questions should be submitted to: MMAC.IHSContracts@dss.mo.gov

Telephone Number: 573-751-3399

Fax Number: 573-634-3105

THIS BLOCK IS FOR STATE USE ONLY:

PROVIDER NUMBER:

KEYED:

EFFECTIVE:

END:

INITIALS: