MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT AND COMPLIANCE UNIT

PROVIDER VOLUNTARY TERMINATION REQUEST

A separate form must be submitted for each provider type and/or individual/group. <u>All Sections MUST be completed</u> and the form must be signed. Include the effective date where indicated. Failure to follow these instructions could result in the denial of your request.

SECTION I: PROVIDER INFORMATION – Fill in applicable fields with provider's current information.

FOR **INDIVIDUAL'S** ONLY: LAST NAME	FIRST NAME	MIDDLE INITIAL	SUFFIX

FOR **AGENCIES** ONLY: PROVIDER NAME	DBA (if applicable)
NATIONAL PROVIDER IDENTIFIER (NPI)	TAXONOMY CODE

SECTION II: CONTACT PERSON – Person that can discuss the requested termination and where notification can be sent.

NAME	TELEPHONE / -	E-MAIL ADDRESS

SECTION III: CHANGE REQUEST – Please provide an updated address.

☐ CURRENT ADDRESS ☐ EDIT EFFECTIVE: / /

ADDRESS CITY STATE ZIP CODE

☐ VOLUNTARILY TERMINATE MEDICAID ENROLLMENT EFFECTIVE: / /

SECTION IV: REASON FOR VOLUNTARY TERMINATION REQUEST/COMMENTS

SECTION V: FUTURE RECORD RETENTION INFORMATION – RECORDS MUST BE STORED FOR 6 YEARS AFTER THE TERMINATION DATE ABOVE (7 YEARS FOR NURSING HOME, CSTAR AND COMMUNITY PSYCHIATRIC REHABILITATION PROGRAMS):

LOCATION WHERE RECORDS WILL BE STORED:

ADDRESS: CITY: STATE: ZIP CODE:

FUTURE CONTACT PERSON NAME:

FUTURE CONTACT PHONE:

FUTURE CONTACT E-MAIL:

PROVIDER OR INDIVIDUAL NAME FROM SECTION I	NPI NUMBER
MUST BE SIGNED BY PROVIDER (Signature)	DATE / /
TYPE OR PRINT NAME	TYPE OR PRINT TITLE

FAX or EMAIL COMPLETED FORM AND ANY REQUIRED DOCUMENTS TO

573/526-2054

MMAC.Terminations@dss.mo.gov

MMAC USE ONLY

The requested change(s) has been: ☐ PROCESSED ☐ DENIED

REASON FOR DENIAL

PROCESSED BY	DATE / /

(01/25)