MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT AND COMPLIANCE UNIT

PROVIDER UPDATE REQUEST

You must submit a separate form for each provider type and/or individual/group. You MUST complete Sections 1 and 2 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 1: PROVIDER INFORMATION – complete **ONE** of the below - for either a group or an individual provider

INDIVIDUAL PROVIDER:

LAST NAME		FIRST NAME
MIDDLE INITIAL	SUFFIX	INDIVIDUAL PROVIDER'S NPI

GROUP PROVIDER:

LEGAL BUSINESS NAME AS REGISTERED WITH THE IRS	
DBA (if applicable)	
GROUP PROVIDER'S NPI	TAXONOMY CODE

SECTION 2: CONTACT PERSON – Authorized person able to discuss the requested change & where notification can be sent.

NAME	**TELEPHONE**	**E-MAIL ADDRESS**

SECTION 3: MAIN LOCATION CHANGE - List additional locations on a separate sheet.
THE FOLLOWING PROVIDERS CANNOT USE EMOMED TO UPDATE ADDRESSES –APRNs, Nurse Midwives, Assistant Physicians, Home & Community Based providers, clinics, and some other organization types.
ALL OTHER PROVIDERS PLEASE UTILIZE THE ADDRESS FUNCTION IN EMOMED.

☐ MAIN PHYSICAL LOCATION ☐ EDIT ☐ DELETE EFFECTIVE DATE:
ADDRESS CITY STATE ZIP: COUNTY:
GROUP NPI IF APPLIABLE:
BUSINESS PHONE NUMBER: BUSINESS E-MAIL: BUSINESS FAX NUMBER:

☐ REMITTANCE/ PAY TO ADDRESS ☐ EDIT ☐ DELETE EFFECTIVE DATE:
ADDRESS CITY STATE ZIP: GROUP NPI IF APPLIABLE:

IF THE REMITTANCE/ PAY TO NAME AND EFT ARE CHANGING - COMPLETE SECTIONS 7 ON PAGE 2 AND SUBMIT ALL REQUIRED DOCUMENTS.

SECTION 4: ADDITIONAL PRACTICE LOCATION - List additional locations on a separate sheet.
PROVIDERS WHO CANNOT USE EMOMED TO UPDATE ADDRESSES - Institutional Providers (Groups, Clinics, etc.), APRNs, Nurse Midwife, Assistant Physicians
ALL OTHER PROVIDERS: PLEASE USE THE ADDRESS FUNCTION IN EMOMED.

☐ **ADDITIONAL PRACTICE LOCATION** ☐ ADD ☐ EDIT EFFECTIVE DATE:
ADDRESS CITY STATE ZIP: COUNTY:
GROUP/ PRACTICE NPI: PHONE #:

☐ **DELETE A PRACTICE LOCATION OR REMOVE INDIVIDUAL IN SECTION 1 FROM THE FOLLOWING LOCATION (NOTE: Removing an individual from a location does not terminate their enrollment.)**
GROUP NAME: GROUP NPI: EFFECTIVE DATE:
GROUP ADDRESS/CITY/STATE/ZIP:

SECTION 5: LICENSURE & NAME CHANGES

☐ PROVISIONALLY LICENSED PROFESSIONAL COUNSELOR TO LICENSED PROFESSIONAL COUNSELOR - *Attach a copy of the license.*

☐ LICENSE EXPIRATION DATE - Attach a copy of the license.

☐ INDIVIDUAL NAME CHANGE:
Attach a copy of the individual's current licensure issued in the new name.

SECTION 6: ADDING ITEMS TO RECORD:

☐ ADVANCED PRACTICE NURSE/NURSE MIDWIFE MEDICATION PRESCRIBER – 28 specialty code
*Attach a copy of the collaborative practice agreement (CPA) – ALL addresses on file **MUST** be listed on the CPA.*
IF THE COLLABORATIVE PRACTICE AGREEMENT IS NOT SUBMITTED, MMAC WILL BE UNABLE TO PROCESS THE REQUEST.

☐ MEDICARE NUMBER (if applicable):

☐ CLIA NUMBER (if applicable): *Attach copy of certificate*

☐ OTHER – MAKE CLEAR NOTES IN SECTION 9 on the next page – attach documentation as needed.

SECTION 7: CHANGE IN PAY TO INFORMATION –FOR BUSINESSES, OR INDIVIDUAL PROVIDERS PAYING BACK TO THEMSELVES OR AN ENTITY NOT ENROLLED WITH MO MEDICAID.

☐ **Complete section 3 and supply the following documents.**

1. **Business Organizational Structure form and all documents indicated under the Section completed on the form listing all managing employees and owners with full name, SSN and date of birth.**
2. **Copy of the Federal Tax ID number notification from the IRS that includes the new agency name – or a copy of the provider's social security card if paying back to an SSN instead of an EIN.**
3. **DSS-MMAC EFT Form**
4. A preprinted voided check, deposit slip, or bank letter including business name, account and routing number.

SECTION 8: CHANGE IN ENTITY/AGENCY NAME, EIN, NPI, OR OWNERSHIP

Changes of ownership or control of any provider must be reported to MMAC within 30 days of the change.

☐ **AGENCY NAME CHANGING TO:**

1. **Business Organizational Structure form and all documents indicated under the Section completed on the form listing all managing employees and owners with full name, SSN and date of birth.**
2. **Copy of the Federal Tax ID number notification from the IRS that includes the new agency name**
3. **Documentation from CMS NPPES with NPI information for new agency name. (https://nppes.cms.hhs.gov/#/)**
4. **Copy of licensure under the new name (if applicable)**

☐ **CHANGE IN FEDERAL TAX ID (FEIN) OR NPI - (WHEN OWNERSHIP REMAINS THE SAME)**

NEW EIN:	OLD EIN:
NEW NPI	OLD NPI

1. **Copy of the Federal Tax ID number notification from the IRS that includes the new agency name**
2. **Copy of current NPPES letter if changing NPI**

☐ **SALE/TRANSFER OF ASSETS OR CHANGE OF OWNERSHIP**

1. **Business Organizational Structure form and all documents indicated under the Section completed on the form listing all managing employees and owners with full name, SSN and date of birth.**
2. **Copy of the Federal Tax ID number notification from the IRS that includes the new agency name**
3. **Copy of Merger/Sale/Legal documents showing the changes**
4. **DSS-MMAC EFT Form**
5. **Copy of current NPPES letter if changing NPI**
6. **Operating Agreement, Partnership Agreement or Articles of Incorporation (as applicable)**

Seller's name:	
Buyer's name:	
Buyer contact person:	
Buyer Phone number:	
Buyer Mailing address – include city, state and zip:	
Date selling provider will cease business:	Effective date of sale:

Location where records will be stored at for 5 years (7 years for the Nursing Home, CSTAR and Community Psychiatric Rehabilitation Programs) after the date of termination listed above (city/state/zip):

ADDRESS: CITY: STATE: ZIP CODE:

Future Contact Person Name:
Future Contact Phone:
Future Contact E-mail:

SECTION 9: NOTES – ANYTHING NOT REFERENCED IN ANY SECTION ABOVE. PLEASE BE DESCRIPTIVE.

THE AUTHORIZED SIGNER OF THIS DOCUMENT VERIFIES THAT HE/SHE IS AN INDIVIDUAL OR THE REPRESENTATIVE OF THE PROVIDER AND IS THE DULY AUTHORIZED AGENT TO EXECUTE THIS CHANGE REQUEST DOCUMENT ON BEHALF OF THE PROVIDER UNDER AUTHORITY GRANTED BY SAID PROVIDER.

(Signature)	DATE
TYPE OR PRINT NAME OF PERSON SIGNING	**TYPE OR PRINT NAME OF PERSON SIGNING**

FAX COMPLETED FORM AND ANY REQUIRED DOCUMENTS TO 573-634-3105

MMAC PROVIDER ENROLLMENT USE ONLY

CLERK COMMENTS BELOW:	The requested change(s) has been:	☐ PROCESSED	☐ REJECTED
PROCESSED BY **CLERK**	DATE		