DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT AND COMPLIANCE UNIT

MISSOURI MEDICAID ADULT DAY CARE PROVIDER QUESTIONNAIRE

PLEASE TYPE OR PRINT ALL FORMS CLEARLY

1. LEGAL PROVIDER NAME			
2. DOING BUSINESS AS (DBA) NAME			
3. PHYSICAL ADDRESS	4. CITY	5. STATE	6. ZIP CODE
7. MAILING ADDRESS	8. CITY	9. STATE	10. ZIP CODE
11. COUNTY WHERE OFFICE IS LOCATED	12. ADULT DAY CARE LICENSE NUMBER		
13. FEDERAL EMPLOYER IDENTIFICATION NUMBER	14. NPI NUMBER		
15. ON-SITE MANAGER OR CONTACT PERSON	16. DAYS AND HOURS OF OPERATION		
17. TELEPHONE NUMBER ( ) -	18. E-MAIL ADDRESS		

On behalf of the applying provider, I affirm that all documents and information submitted pursuant to this application for enrollment are true and correct to the best of my knowledge and belief and that all required documents are included with this enrollment packet.

I further affirm I am an individual or the representative of the applying provider and am the duly authorized agent to execute this document on behalf of the applying provider under authority granted by said applying provider.

SIGNATURE OF AUTHORIZED SIGNEE	DATE
PRINTED NAME OF AUTHORIZED SIGNEE	

COMPLETE ALL FORMS AND RETURN TO

Missouri Medicaid Audit and Compliance
Provider Contracts
205 Jefferson Street, 2nd Floor
P.O. Box 6500
Jefferson City, MO 65102

mmac.ihscontracts@dss.mo.gov

FAX: 573-751-5065

FOR MMAC USE ONLY

Provider Type – 29	Specialty – 50
Provider Number:	
Effective Date:	
End Date:	
Keyed Date:	
Keyed By:	