MISSOURI DEPARTMENT OF SOCIAL SERVICES (DSS)
MO HEALTHNET DIVISION (MHD)

LONG TERM CARE PHARMACY DISPENSING FEE PROVIDER SPECIALTY APPLICATION

PROVIDER INFORMATION

Complete or affix provider label below:

MO HEALTHNET PROVIDER IDENTIFIER	PROVIDER TOXONOMY CODE

PHARMACY NAME	BUSINESS TELEPHONE

PHARMACY ADDRESS

APPLICATION

1. FACILITIES FOR WHOM YOU DISPENSE IN UNIT-DOSE OR CONTROLLED-DOSE DRUG DISTRIBUTION SYSTEM. FACILITY NAME(S): EX-FACILITY NAME	2. TYPE OF UNIT-DOSE OR CONTROLLED-DOSE DRUG DISTRIBUTION SYSTEM DISPENSED IN EACH FACILITY. DRUG SYSTEM FOR THAT FACILITY

By my signature, I hereby certify that I provide the required distribution system as stated above, and that I provide emergency services and 24 hour a day, seven (7) day a week availability to the long term care facility. In addition, I am able and willing to assist the facility and its residents in accessing medications through the MO HealthNet exception process.

PROVIDER'S ORIGINAL SIGNATURE	PRINT NAME AND TITLE OF PERSON SIGNING	DATE SIGNED

RETURN TO:
Provider Enrollment Unit
MO HealthNet Division
PO Box 6500
Jefferson City, MO 65102
email: providerenrollment@dss.mo.gov