|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **STATE OFFICE**  **USE ONLY** | | PROVIDER IDENTIFIER: | | | | | | | EFF: | | | | STATUS: | | |
|  | | PARM: | | | CLINIC/GROUP #: | | | | END: | | | | | | |
|  | | CROSS REF: | | | | | | | KEYED: | | | | INITIALS: | | |
|  | DEPARTMENT OF SOCIAL SERVICES  MISSOURI MEDICAID AUDIT AND COMPLIANCE  **MISSOURI MEDICAID REASSESSMENTS PROVIDER QUESTIONNAIRE** | | | | | | | | | | | | | | |
| *(PLEASE TYPE OR PRINT ALL FORMS IN BLACK INK)* | | | | | | | | | | | | | | | |
| PROVIDER NAME AS LICENSED | | | | | | | | | | | | STATE OFFICE USE ONLY | | | |
|  | | | | | | | | | | | |  | | | |
| PROVIDER ADDRESS AS LICENSED (do not use PO Box only) | | | | | | | | CITY | | | | COUNTY | | STATE | ZIP  CODE |
|  | | | | | | | |  | | | |  | |  |  |
| PROVIDER NAME, AS REGISTERED WITH THE IRS, THAT MATCHES THE NUMBER ENTERED IN FIELD 14 This information will be used for paper checks, remittance advices, and tax records. Indicate entity name and doing business as (DBA) name, if applicable. | | | | | | | | | | | | | | | |
|  | | | | | | | | DBA | | | | | | | |
| REMITTANCE ADVICE ADDRESS (do not use a bank address) | | | | | | | | CITY | | | | | | STATE | ZIP CODE |
|  | | | | | | | |  | | | | | |  |  |
| NUMBER THAT MATCHES THE NAME IN FIELD 9 AND ENTER THE NUMBER | | | | | | | | | | | | | | | |
| Social Security Number: **-    -**  Federal Employer Tax ID No - used for IRS reporting: **-** | | | | | | | | | | | | | | | |
| BUSINESS TELEPHONE NUMBER (INCLUDE AREA CODE) | | | | | | | | PROVIDER TYPE | | | | | | | |
| (  ) **-** | | | | | | | | **27 REASSESSMENTS** | | | | | | | |
| TYPE OF PRACTICE | | | | | | | | | | | | | | | |
| Individual | | | Partnership | Hospital-Based Physician | | | | | | Corporation | | | | | |
| Charitable | | | City, Municipal, County, District, State Owned | | | | | | | Privately Owned/Sole Proprietor | | | | | |
| MEDICAID PROGRAMS CURRENTLY ENROLLED IN AND NPI | | | | | | | | | | | | | | | |
| Personal Care (in-home services only)  NPI: | | | | | | Aged & Disabled Waiver  NPI: | | | | | Consumer Directed Services  NPI: | | | | |
| Residential Care Facility – Personal Care  NPI: | | | | | | Adult Day Care Waiver  NPI: | | | | | Independent Living Waiver  NPI: | | | | |
| NATIONAL PROVIDER IDENTIFIER (NPI) FOR THIS APPLICATION. If using one NPI for multiple MO HealthNet provider programs, the Provider Taxonomy Code that pertains to this application must also be entered. Visit <https://nppes.cms.hhs.gov/NPPES/Welcome.do> to apply for an NPI or <http://www.wpc-edi.com/codes/taxonomy> for a list of valid provider taxonomy codes. | | | | | | | | | | | | | | | |
| NPI: | | | | | | | Taxonomy Code: | | | | | | | | |
| **COMPLETE AND RETURN ALL FORMS TO**  Missouri Medicaid Audit and Compliance – Provider Enrollment Contracts Section  Mailing Address: PO Box 6500, Jefferson City, MO 65102-6500  Physical Address: 205 Jefferson Street, 2nd Floor, Jefferson City, MO 65101  FAX 573-751-5065  E-mail address: [mmac.ihscontracts@dss.mo.gov](mailto:mmac.ihscontracts@dss.mo.gov) | | | | | | | | | | | | | | | |

(05/2017)