STATE OF MISSOURI
DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT AND COMPLIANCE
HCBS VOLUNTARY TERMINATION REQUEST

SECTION 1: PROVIDER INFORMATION – COMPLETE ALL APPLICABLE FIELDS IN A LEGIBLE MANNER. Please complete ONE form per provider EIN. THIS IS A REQUIRED SECTION.

LEGAL AGENCY NAME AS IT APPEARS WITH THE IRS:	**DOING BUSINESS AS NAME (IF APPLICABLE):**
NPI:	**SSBG (optional):**

☐ CDS	☐ In-Home	☐ Reassessments	☐ Adult Daycare	☐ RCF (Residential Care)	☐ ALF (Assisted Living)

EMAIL ADDRESS FOR CONFIRMATION OF CHANGES:

SECTION 2: VOLUNTARILY TERMINATE ENROLLMENT – Effective Date Must Be Consistent On All Documents Submitted.

THE FOLLOWING MUST BE ATTACHED – USE THE CHECKBOXES TO CHECK OF DOCUMENTS:

1. ☐ A letter stating that you wish to terminate your enrollment with MO HealthNet – include your NP and effective date in the letter.
2. ☐ A copy of the letter that you sent to the Department of Health and Senior Services letting them know the effective date you will be terminating your enrollment with MO HealthNet.
3. ☐ A copy of the letter that was sent to the participants letting them know the effective date you will be terminating your enrollment and that they will need to find a new provider.
4. ☐ List of Medicaid Participant DCNs serviced by your entity.

I WISH TO VOLUNTARILY TERMINATE MY ENROLLMENT WITH MOHEALTHNET EFFECTIVE - LIST MM/DD/YYYY IN BLANK BELOW. DATE MUST BE LISTED ON BLANK TO PROCESS CORRECTLY.
EFFECTIVE (MM/DD/YYYY): _____

Location where records will be stored for 5 years after the date of termination listed above:

ADDRESS:	**CITY:**	**STATE:**	**ZIP:**

Future contact person name:

Future contact phone:

Future contact e-mail:

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

(Original Signature) **Electronic signature is not acceptable.**	**Date:**
TYPE OR PRINT NAME OF AUTHORIZED PERSON SIGNING:	**TYPE OR PRINT TITLE OF AUTHORIZED SIGNER:**

PLEASE FAX FORM & ALL DOCUMENTS TO 573-634-3105. DO NOT EMAIL FORM Unless Instructed.
ALL OF THE REQUIRED DOCUMENTATION MUST BE SUBMITTED TO PROCESS YOUR REQUEST.

MISSOURI MEDICAID AUDIT AND COMPLIANCE USE ONLY BELOW:

☐ APPROVED	☐ REJECTED

SENT TO: ☐ **DHSS** ☐ **Terminations** ☐ **Others (as needed)**

MMAC STAFF ID/SIGNATURE:	**DATE:**