



DEPARTMENT OF SOCIAL SERVICES  
 MISSOURI MEDICAID AUDIT & COMPLIANCE  
 MISSOURI MEDICAID "AGED & DISABLED WAIVER" PROVIDER QUESTIONNAIRE

PLEASE TYPE OR PRINT ALL FORMS IN BLACK INK  
 ANSWERS ARE REQUIRED FOR ALL QUESTIONS - USE "N/A" OR "NONE" IF APPLICABLE

PROVIDER AGENCY LEGAL NAME, AS REGISTERED WITH THE IRS AND MO SECRETARY OF STATE

PROVIDER AGENCY DOING BUSINESS AS (DBA) NAME, PREGISTERED WITH MO SECRETARY OF STATE (If applicable)

PROVIDER FULL PHYSICAL ADDRESS

PROVIDER FULL MAILING ADDRESS (for correspondence, remittance advices and tax forms)

NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER

BUSINESS E-MAIL ADDRESS

FEDERAL EMPLOYER IDENTIFICATION NUMBER (EIN) FROM IRS

BUSINESS TELEPHONE NUMBER WITH AREA CODE

BUSINESS FAX NUMBER WITH AREA CODE

NAME OF PRIMARY CONTACT PERSON

DAYS AND HOURS OF OPERATION FOR BUSINESS OFFICE

**CHECK TYPE OF PRACTICE**

INDIVIDUAL PRACTICE     PARTNERSHIP     CORPORATION (INC, LLC)     CHARTABLE     PRIVATELY OWNED   
 CITY, MUNICIPAL, COUNTY, DISTRICT, OR STATE OWNED

SUBMIT THIS FORM WITH REST OF ENROLLMENT PACKET TO:

MISSOURI MEDICAID AUDIT & COMPLIANCE  
 ATTN: CONTRACTS UNIT  
 P.O. BOX 6500  
 20S JEFFERSON STREET, 2nd FLOOR  
 JEFFERSON CITY, MO 65102

Any questions should be submitted to: [MMAC.IHSContracts@dss.mo.gov](mailto:MMAC.IHSContracts@dss.mo.gov)

Telephone Number: 573-751-3399

Fax Number: 573-634-3105

**THIS BLOCK IS FOR STATE USE ONLY**

PROVIDER NUMBER:

KEYED:

EFFECTIVE DATE:

INITIALS: