State of Missouri

Department of Social Services

Missouri Medicaid Audit & Compliance

ENROLLMENT APPLICATION - ORGANIZATION

LIMITED ENROLLMENT FOR MANAGED CARE NETWORK PROVIDER (ORGANIZATION)

To comply with the Medicaid and CHIP Managed Care Final Rule {CMS-2390-F) and 42 CFR § 438.602{b), each State Medicaid Agency {SMA) must screen and enroll all network providers of contracted MCOs. If you execute a network provider agreement with one or more of the contracted MCOs in Missouri, you must submit this enrollment application to the Missouri Medicaid Audit & Compliance {MMAC) Provider Enrollment Unit within 120 days of the effective date of your MCO contract. You only need to submit one application to MMAC, regardless of how many MCOs you hold a contract with. If you do not complete the application process with MMAC, the MCO{s) is required to terminate your network agreement.

Organizational providers completing this application will not submit claims to MO HealthNet, nor will they be required to provide any services to Medicaid Fee for Service participants.

If you are already enrolled with MO HealthNet as a billing or performing provider, you do not need to complete this application.

Please type or print legibly using BLACK OR BLUE INK ONLY, and retain a copy of this entire document for your records.

Fax or email this application to: MMAC Provider Enrollment
205 Jefferson Street, 2nd Floor
P.O. Box 6500
Jefferson City, MO 65102
Fax: 573-634-3105
Email: mmac.providerenrollment@dss.mo.gov

Provider Enrollment Application Instructions for MCO Network Provider (Organization)

This application is to be used by organizational providers and only if you are enrolling for the sole purpose of meeting the federally mandated requirements of the Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) and 42 CFR § 438.602(b). All questions must be completed. Attach additional sheets if necessary to answer each question completely and each additional sheet must display the relevant question number from the application.

If your organization is already enrolled with MO HealthNet and you only need to update information, please complete and submit a Provider Update Form. If you want to terminate your MO HealthNet enrollment, please complete a Provider Update Form.

Requirements:

42 CFR § 438.602{b) states: **(1) The State must screen and enroll, and periodically revalidate, all network providers of MCOs**, PIHPs, and PAHPs, in accordance with the requirements of part 455, subparts B and E of this chapter. This requirement extends to PCCMs and PCCM entities to the extent the primary care case manager is not otherwise enrolled with the State to provide services to Fee-For-Services {FFS) beneficiaries. This provision does not require the network provider to render services to FFS beneficiaries. **(2) MCOs**, PIHPs, and PAHPs **may execute network provider agreements pending the outcome of the process in paragraph (b)(1) of this section up to 120 days, but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one 120 day period without enrollment of the provider**, and notify affected enrollees.

This requirement will apply to Ordering, Prescribing, and Referring {OPR) providers in a managed care setting as well.

- **If you are already enrolled with MO HealthNet , you do not need to completethis application.**

- This application is solely for MCO Network providers not participating with the MO HealthNet Fee for Service program. If at any time you would like to become a fully participating MO HealthNet provider, you must submit a new enrollment application form for your specific provider type.

- You must have a ten digit National Provider Identifier {NPI). The NPI is the standard, unique health identifier for health care providers and is assigned by the NationalPlan and Provider Enumeration System {NPPES).

    - The NPI must be for an organization {not an individual physician or non-physicianpractitioner NPI).
    - Applying for the NPI is a separate process from MO HealthNet enrollment.
    - To obtain an NPI, apply online at https://nppes.cms.hhs.gov.
    - For more information about NPI enumeration, visit www.cms.gov/NationalProvIdentStand.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT & COMPLIANCE

MO HEALTHNET PROVIDER ENROLLMENT APPLICATION - ORGANIZATION LIMITED ENROLLMENT FOR MANAGED CARE NETWORK PROVIDER

THIS FORM IS MANDATORY FOR ALL PROVIDERS; READ AND ANSWER ALL QUESTIONS CAREFULLY.

Failure to provide this information is grounds for denial of this application and/or termination of provider participation. A SEPARATE form MUST be completed for each provider identifier. EACH form MUST contain an ORIGINAL SIGNATURE. Answer all questions. Attach an additional sheet to provide complete information for any question. Enrollment inquiries may be directed to Provider Enrollment via e-mail at MMAC.ProviderEnrollment@dss.mo.gov

Provider Agency Legal Name, as registered with the IRS and MO Secretary of State	
Provider Agency Doing Business As (DBA) Name, as registered with MO Secretary of State - (If applicable)	
Provider Agency Full Physical Address	**County**
Provider Agency Full Mailing Address	**County**

National Provider Identifier (NPI) Number	**Business E-mail Address**
Federal Employer Identification Number (EIN) from IRS	**Business Telephone Number**
Medicare Number (If applicable)	**Business Fax Number**
License Number and Issuing State (If applicable)	**Contact Person's Name**
DEA Number (If applicable)	**CLIA Number (If applicable)**

National Council for Prescription Drug Programs (NCPDP) Identification Number (If applicable)

Type of Practice:

Partnership ☐ **Corporation (INC, LLC)** ☐ **Charitable** ☐ **Privately Owned** ☐
City, Municipal, County, District, or State Owned ☐

All applying providers must submit the attached **Business Organizational Structure (BOS)** form to comply with federal and state Medicaid regulations requiring disclosure of all individuals and/or business organizations that have direct or indirect ownership, management and/or control interests.

In addition to submitting the Business Organizational Structure (BOS) form, providers may utilize separate documents (i.e. organizational chart, spreadsheet, etc.) to identify individuals and businesses with ownership or control interests andall "managing employees" as defined in 13 CSR 65-2.010(25). Those documents must contain the full name (First, middle,last and suffix Jr., Sr., etc.), date of birth, and social security number of each individual who has 5% or greaterdirect/indirect ownership, controlling interest, partnership interest; any contractor or subcontractor; managing employees; officers or directors; or the legal business name and federal EIN of any organization(s) having direct or indirectownership or controlling interest. A current copy of the provider's Ownership & Disclosure documents submitted to a Managed Care Organization {MCO) or the portion of a Medicare CMS-855 that includes the required information may be submitted, if one has been completed.

Indicate Your Provider Type:

- ___ Adult Day Health Care 29
- ___ Aged & Disabled Waiver 28
- ___ Alcohol and Drug Rehabilitation 86
- ___ Ambulance 80
- ___ Audiologist 33
- ___ Birthing Centers 61
- ___ Care Coordinator 44
- ___ Case Management 18
- ___ Chiropractor 95
- ___ Community Mental Health Dept Ctr 56
- ___ Comprehensive Rehab 76
- ___ CRNA/AA Services 91
- ___ Dental Hygienist 74
- ___ Dentist 40
- ___ Disease Mgmt {Diabetes care) 35
- ___ DME Supplier 62
- ___ Full Service PHP 92
- ___ General Hospital 01
- ___ Hearing Aid Specialist 34
- ___ Home Health Agency 58
- ___ Hospice 82
- ___ Indep or Portable X-ray/IDTF 71
- ___ Independent Clinic - Includes FQHC
- ___ Independent Laboratory 70
- ___ Psych Hospital 02
- ___ NEMT 65
- ___ Nurse Midwife 25
- ___ Nurse Practitioner {Advanced) 42
- ___ Nursing Home 10
- ___ Nutrition Consultant 43
- ___ Occupational Therapist 47
- ___ Optician 32
- ___ Optometrist 31
- ___ Personal Care 26
- ___ Pharmacy 60
- ___ Physical Therapist 48
- ___ Physician, DO 24
- ___ Physician, MD 20
- ___ Podiatrist 30
- ___ Podiatry Clinic 36
- ___ Private Duty Nurse 94
- ___ Private Home - ICF/MR Home 11
- ___ Professional Clinic - Optometry 53
- ___ Psychiatric Rehabilitation 87
- ___ Psychologist 49
- ___ Public Health Dept Clinic 51
- ___ Rehabilitation Center 57
- ___ Rural Health Clinic {RHC) 59
- ___ School Services 96
- ___ Speech Therapist 46
- ___ Other Specialties not listed:

Indicate Your Specialty:

Physician Specialties: If you are a physician, designate your specialties. Check all that apply. A physician must meet all federal and state requirements for specialties checked.

- Addiction Medicine
- Allergy/Immunology
- Anesthesiology
- Cardiac electrophysiology
- Cardiac surgery
- Cardiovascular disease {Cardiology)
- Colorectal surgery {Proctology)
- Critical Care {Intensivists)
- Dermatology
- Diagnostic Radiology
- Emergency Medicine
- Endocrinology
- Family practice
- Gastroenterology
- General practice
- General surgery
- Geriatric medicine
- Geriatric psychiatry
- Gynecological oncology
- Hand surgery
- Hematology
- Hematology/Oncology
- Hospice
- Infectious disease
- Internal medicine
- Interventional pain management
- Interventional radiology
- Medical oncology
- Nephrology
- Neurology
- Neuropsychiatry
- Neurosurgery
- Nuclear Medicine
- Obstetrics/Gynecology
- Ophthalmology
- Optometry
- Oral Surgery {Dentist Only)
- Orthopedic surgery
- Osteopathic manipulative medicine
- Otolaryngology
- Pain Management
- Palliative care peripheral vascular disease
- Physical medicine and rehabilitation
- Plastic and reconstructive surgery
- Podiatry
- Preventative medicine
- Psychiatry
- Pulmonary disease
- Radiation oncology
- Rheumatology
- Sports Medicine
- Surgical oncology
- Thoracic surgery
- Urology
- Vascular surgery
- Unlisted physician type
  Specify:

Non-Physician Specialties: If you are a non-physician practitioner, check the appropriate box to indicate your specialty. Check only one. All non-physician practitioners must meet specific licensing, educational, and work experience requirements.

- Certified Nurse Midwife
- Certified Registered Nurse Anesthetist
- Nurse Practitioner
- Clinical Psychologist
- Clinical Social Worker
- Dentist
- Physician Assistant
- Unlisted non-physician practitioner type
  Specify:

NUMBERS 1 THROUGH 13 – IF YOU ARE AN AUTHORIZED REPRESENTATIVE COMPLETING THIS APPLICATION FOR A HEALTH CARE ORGANIZATION, YOU SHOULD ANSWER EACH QUESTION ON BEHALF OF ALL INDIVIDUALS WHO HAVE BEEN IDENTIFIED AS HAVING AN OWNERSHIP OR CONTROLLING INTEREST, AND THOSE IDENTIFIED AS MANAGING EMPLOYEES. IF THE ANSWER IS YES TO ANY OF THESE QUESTIONS, AN EXPLANATION, DATE, STATE, CITY AND COUNTY, MUST BE COMPLETED. INCLUDE ADDITIONAL SHEETS AND/OR ATTACHMENTS IF NECESSARY.

1. Has the applying provider, any managing employee, or any person having an ownership or control interest; ever been personally terminated, denied enrollment, suspended, restricted by agreement, or otherwise sanctioned by Medicare, Medicaid, MO HealthNet, or ANY state or federal programs in ANY state? Yes ☐ No ☐
Incidents where notice of program deficiency resulted in voluntary withdrawal must be included.

2. Has the applying provider, any managing employee, or any person having an ownership or control interest for the applying provider; ever had ownership, indirect ownership, controlling interest, or been administrator of a facility or agency that has been terminated, denied enrollment, suspended, restricted by agreement, other otherwise sanctioned by Medicare, Medicaid, MO HealthNet or ANY state or federal programs in ANY state? Yes ☐ No ☐
Incidents where notice of program deficiency resulted in voluntary withdrawal must be included.

3. Has the license of the applying provider, any managing employee, or any person having an ownership or control interest; ever been revoked, suspended, surrendered, or in any way restricted by probation or agreement by ANY licensing authority in ANY state? Yes ☐ No ☐

4. Is there any proceeding currently pending to revoke, suspend, censure or restrict by probation or agreement, the license of the applying provider, any managing employee, or any person having an ownership or control interest; in Missouri or in ANY state? Yes ☐ No ☐

5. Does the applying provider, any managing employee, or any person having an ownership or control interest; have any outstanding criminal fines, restitution orders, or overpayments pertaining to health care in Missouri or ANY other state? Yes ☐ No ☐

6. Has the applying provider, any managing employee, or any person having an ownership or control interest; ever been convicted of a crime, excluding minor traffic citations? Yes ☐ No ☐
If yes, list conviction{s), when, and where:

7. Are there any criminal proceedings currently pending for the applying provider, any managing employee, or any person having an ownership or control interest; or any individual involved with the applying provider's practice, clinic, group, corporation or any other association? Yes ☐ No ☐
If yes, list pending changes and location:

8. Is the applying provider, any managing employee, or any person having an ownership or control interest; related, including but not limited to, a spouse, parent, child, sibling, etc., to any owner, officer, agent, managing employee, director or shareholder that has been convicted of a crime pertaining to health care services?
Yes ☐ No ☐
If yes, list conviction, date and location:

9. Does the applying provider now hold a certificate to dispense controlled substances from the federal Drug Enforcement Agency {DEA), the Missouri Bureau of Narcotics and Dangerous Drugs {BNDD), or any other state?
Yes ☐ No ☐ If yes, list all states, certificate numbers, AND #12 MUST BECOMPLETED.

DEA Number: BNDD Number:
DEA Number: BNDD Number:

10. Has the DEA or BNDD certificate ever been suspended, revoked, surrendered, or in any way restricted by probation or agreement? Yes ☐ No ☐ If yes, explain with date, state, city, county, and included attachments.

11. Does the applying provider have any pending enrollment applications with any other state or federal program, other than this application? Yes ☐ No ☐ If yes, list state and program:

12. Does the applying provider, any managing employee, or any person having an ownership or control interest; have any pending complaint investigations being reviewed by any professional boards?
Yes ☐ No ☐ If yes, explain:

13. Does the applying provider, any managing employee, or any person having ownership or control interest; or any individual involved with the applying provider's practice, clinic, group, corporation or any other association, have any outstanding overpayments to Medicare, Medicaid, or any other federal/state health care programs?
Yes ☐ No ☐ If yes, explain:

☐ By checking this block, I certify that I have reviewed the federal and state disclosure regulations for all applying Medicaid providers which are attached to this enrollment application. I also certify that all individuals and/or business organizations with direct or indirect ownership, management and/or control interests have been fully disclosed.

To the best of my knowledge, the information supplied on this application is accurate, complete and is hereby released to the Missouri Department of Social Services. I also understand that pursuant to 13 CSR 70-3.020{7), I must advise the Department, in writing, of any changes affecting the provider's enrollment record.

ORIGINAL Signature of Applicant or Authorized Representative: (Stamp or other facsimile is not acceptable)

Type or print name and title of person signing this application:	**Date Signed**:

Submit this enrollment application and all attachments to:

Missouri Medicaid Audit & Compliance
Attn: Provider Enrollment Unit
205 Jefferson Street, 2nd Floor
P.O. Box 6500
Jefferson City, MO 65102

Fax: 573-634-3105

Email submissions and questions: MMAC.ProviderEnrollment@dss.mo.gov

Federal and State Disclosure Requirements for Medicaid Providers

42 CFR § 455.104 Disclosure by Medicaid providers and fiscal agents: Information on ownership and control.

{a) Who must provide disclosures. The Medicaid agency must obtain disclosures from disclosing entities, fiscal agents, and managed care entities.

{b) What disclosures must be provided. The Medicaid agency must require that disclosing entities, fiscal agents, and managed care entities provide the following disclosures:

{1){i) The name and address of any person {individual or corporation) with an ownership or control interest in the disclosing entity, fiscal agent, or managed care entity. The address for corporate entities must include as applicable primary business address, every business location, and P.O. Box address.

{ii) Date of birth and Social Security Number {in the case of an individual).

{iii) Other tax identification number {in the case of a corporation) with an ownership or control interest in the disclosing entity {or fiscal agent or managed care entity) or in any subcontractor in which the disclosing entity {or fiscal agent or managed care entity) has a 5 percent or moreinterest.

{2) Whether the person {individual or corporation) with an ownership or control interest in the disclosing entity {or fiscal agent or managed care entity) is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling; or whether the person {individual or corporation) with an ownership or control interest in any subcontractor in which the disclosing entity {or fiscal agent or managed care entity) has a 5 percent or more interest is related to another person with ownership or control interest in the disclosing entity as a spouse, parent, child, or sibling.

{3) The name of any other disclosing entity {or fiscal agent or managed care entity) in which an owner of the disclosing entity {or fiscal agent or managed care entity) has an ownership or controlinterest.

{4) The name, address, date of birth, and Social Security Number of any managing employee of the disclosing entity {or fiscal agent or managed care entity).

{c) When the disclosures must be provided—

{1) Disclosures from providers or disclosing entities. Disclosure from any provider or disclosing entity is due at any of the following times:

{i) Upon the provider or disclosing entity submitting the provider application.

{ii) Upon the provider or disclosing entity executing the provider agreement.

{iii) Upon request of the Medicaid agency during the re-validation of enrollment process under § 455.414.

{iv) Within 35 days after any change in ownership of the disclosing entity.

{2) Disclosures from fiscal agents. Disclosures from fiscal agents are due at any of the following times:

{i) Upon the fiscal agent submitting the proposal in accordance with the State's procurement process.

{ii) Upon the fiscal agent executing the contract with the State.

{iii) Upon renewal or extension of the contract.

{iv) Within 35 days after any change in ownership of the fiscal agent.

{3) Disclosures from managed care entities. Disclosures from managed care entities {MCOs, PIHPs, PAHPs, and HIOs), except PCCMs are due at any of the following times:

{i) Upon the managed care entity submitting the proposal in accordance with the State's procurement process.

{ii) Upon the managed care entity executing the contract with the State.

{iii) Upon renewal or extension of the contract.

{iv) Within 35 days after any change in ownership of the managed care entity.

{4) Disclosures from PCCMs. PCCMs will comply with disclosure requirements under paragraph {c){1) of this section.

{d) To whom must the disclosures be provided. All disclosures must be provided to the Medicaidagency.

{e) Consequences for failure to provide required disclosures. Federal financial participation {FFP) is not available in payments made to a disclosing entity that fails to disclose ownership or control information as required by this section.

[76 FR 5967, Feb. 2, 2011]

42 CFR § 455.105 Disclosure by providers: Information related to business transactions.

{a) Provider agreements. A Medicaid agency must enter into an agreement with each provider under which the provider agrees to furnish to it or to the Secretary on request, information related to business transactions in accordance with paragraph {b) of this section.

{b) Information that must be submitted. A provider must submit, within 35 days of the date on a request by the Secretary or the Medicaid agency, full and complete information about—

{1) The ownership of any subcontractor with whom the provider has had business transactions totaling more than $25,000 during the 12-month period ending on the date of the request; and
{2) Any significant business transactions between the provider and any wholly owned supplier, or between the provider and any subcontractor, during the 5-year period ending on the date of the request.

{c) Denial of Federal financial participation {FFP)

{1) FFP is not available in expenditures for services furnished by providers who fail to comply with a request made by the Secretary or the Medicaid agency under paragraph {b) of this section or under § 420.205 of this chapter {Medicare requirements for disclosure).
{2) FFP will be denied in expenditures for services furnished during the period beginning on the day following the date the information was due to the Secretary or the Medicaid agency and ending on the day before the date on which the information was supplied.

42 CFR § 455.106 Disclosure by providers: Information on persons convicted of crimes.

{a) Information that must be disclosed. Before the Medicaid agency enters into or renews a provider agreement, or at any time upon written request by the Medicaid agency, the provider must disclose to the Medicaid agency the identity of any person who:

{1) Has ownership or control interest in the provider, or is an agent or managing employee of the provider; and

{2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the title XX services program since the inception of those programs.

{b) Notification to Inspector General.

{1) The Medicaid agency must notify the Inspector General of the Department of any disclosures madeunder paragraph {a) of this section within 20 working days from the date it receives theinformation.

{2) The agency must also promptly notify the Inspector General of the Department of any action it takes on the provider's application for participation in the program.

{c) Denial or termination of provider participation.

{1) The Medicaid agency may refuse to enter into or renew an agreement with a provider if any person who has an ownership or control interest in the provider, or who is an agent or managing employee of the provider, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid or the title XX Services Program.

{2) The Medicaid agency may refuse to enter into or may terminate a provider agreement if it determines that the provider did not fully and accurately make any disclosure required under paragraph {a) of this section.

Missouri Regulation - 13 CSR 65-2.020(3) - Provider Enrollment and Application

{3) All providers, fiscal agents, and managed care entities are required to disclose as follows:

{A) The following disclosures are mandatory:

1. The name and address of any person with an ownership or control interest in the applying provider. The address for corporate entities must include as applicable primary business address, every business location, and PO Box address;

2. Date of birth and Social Security number {in the case of a corporealperson);

3. Other tax identification number of any person with an ownership or control interest in the applying provider or in any subcontractor in which the applying provider has a five percent {5%) or more interest;

4. Whether any person with an ownership or control interest in the applying provider is related to another person with ownership or control interest in the applying provider as a spouse, parent, child, or sibling;

5. Whether any person with an ownership or control interest in any subcontractor in which the applying provider has a five percent {5%) or more interest is related to another person with ownership or control interest in the applying provider as a spouse, parent, child, or sibling;

6. The name of any other provider or applying provider in which an owner of the applying provider has an ownership or control interest; and

7. The name, address, date of birth, and Social Security number of any managing employee of the applying provider;

{B) Disclosures from any provider or applying provider are due at the following times, and must be updated within thirty-five {35) days of any changes in information requiredto be disclosed:

1. Upon the provider or applying provider submitting an application; and

2. Upon request of MMAC;

{C) Disclosures from fiscal agents are due at the following times:

1. Upon the fiscal agent submitting the proposal;

2. Upon request of MMAC;

3. Ninety {90) days prior to renewal or extension of the contract; and

4. Within thirty-five {35) days after any change in ownership of the fiscal agent;

{D) Disclosures from managed care entities {managed care organizations, prepaid inpatient health plans, prepaid ambulatory health plans, and health insuring organizations), except primary care case management programs, are due at the following times:

1. Upon the managed care entity submitting the proposal;

2. Upon request of MMAC; and

3. Ninety {90) days prior to renewal or extension of the contract;

{E) Disclosures from Primary Care Case Management Programs {PCCM). PCCMs will comply with disclosure requirements under subsection {B) of this section;

{F) All Disclosures must be provided to MMAC. Disclosures not made to MMAC will be deemed non-disclosed and not in compliance with this section; and

{G) Consequences for Failure to Provide Required Disclosures.

1. Any person's failure to provide, or timely provide, disclosures pursuant to this section may result in deactivation, denial, rejection, suspension, or termination. If the failure is inadvertent or merely technical, MMAC may choose not to impose consequences if, after notice, the person promptly corrects the failure.

MISSOURI DEPARTMENT OF SOCIAL SERVICES (DSS) – MEDICAID AUDIT AND COMPLIANCE (MMAC)
TITLE XIX PARTICIPATION AGREEMENT MO HEALTHNET PROVIDERS

BY MY SIGNATURE BELOW, I, THE APPLYING PROVIDER, READ AND AGREE THAT, upon the acceptance of my enrollment, I will participate in the Managed Care Organization process or Vendor Payment plan for Medicaid Services as it pertains to my enrollment. I am responsible for all services provided and all billing done under my provider number regardless to whom the reimbursement is paid. It is my legal responsibility to ensure that the proper billing code is used and indicate the length of time I actually spend providing a service regardless to whom the reimbursementis paid. I agree to be financially responsible for all services which are not documented. I agree the Missouri Title XIX Medicaid manual, bulletins, rules, regulations and amendments thereto shall govern and control my delivery of service, and further agree to thefollowing terms:

1. I agree that it is my responsibility to access manual materials that are available from DSS/MMAC over the Internet. I will comply with the Medicaid manual, bulletins, rules, and regulations as required by the DSS/MMAC and the United States Department of Health and Human Services in the delivery of services and merchandise and in submitting claims for payment. I understand that in my field of participation I am not entitled to Medicaid reimbursement if I fail to so comply, and that I can be terminated from the program for failure to comply;
2. The rate of reimbursement for services will be based on charges established and determined by the DSS/MMAC Medicaid manual, bulletins, and amendments thereto in accordance with the Vendor Payment Program, and that charges will not exceed those to the general public for the same services;
3. I agree that the selection of an electronic or Internet claim processing method in no way modifies any requirements of the Missouri Medicaid program policies or procedures except those dealing with claim submission. I understand that all data elements required by DSS/MMAC for paper claims are required for claims submitted electronically, and that those claims not meeting required specifications will not be processed. In the event that DSS/MMAC places me on prepayment review , as authorized by State Regulation 13 CSR 70-3.030, or on a closed-end agreement, I agree to submit all claims on paper until notified by DSS/MMAC that electronic or Internet billing can resume;
4. I understand that I cannot collect for Title XIX covered services from the recipient-patient, his or her spouse, parent, guardian, relative or anyone else receiving public assistance, and if any payment is received or assured from any other source on the recipient-patient's account, that amount will be deducted from the claim I filed with Title XIX Medicaid. I also understand that I must report any payment so received after provider payment is made by Title XIX to the DSS/MMAC for appropriate adjustment action;
5. I agree that I and any contractor, employees, or subcontractors of mine, shall comply with all applicable provisions of State and Federal laws and regulations pertaining to nondiscrimination, sexual harassment and equal employment opportunity including, but not limited to, the following laws and regulations and all subsequent amendments thereto:

    A. The United States Civil Rights Act of 1964 (as amended), (42 U.S.C. 2000a-2000h)
    B. The United States Civil Rights Act of 1964 (as amended), (Title VI; 42 U.S.C. 2000d et seq.) (See also guidelines to Federal Financial Assistance Recipients regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons)
    C. Section 504 of the Rehabilitation Act of 1973, (29 U.S.C. 794)
    D. The Age Discrimination Act of 1975, (42 U.S.C. 6101, et seq.)
    E. The Omnibus Budget Reconciliation Act of 1981
    F. The Americans with Disabilities Act of 1990, (42 U.S.C.12101 et seq.)
    G. Executive Orders 11246 and 11375, (Equal Employment Opportunity) and Executive Order 13166 (2000), (Improving Access to Services for Persons with Limited English Proficiency)
    H. The Missouri Human Rights Act (Mo. Rev. Stat. Chapter 213)

    I and any contractor or subcontractor of mine may not, on the grounds of race, color, national origin, creed, sex, religion, age or disability exclude persons from employment in, deny participation in, deny benefits to, or otherwise subject persons to discrimination under the Medicaid program or any activity connected with the provision of Medicaid services.
6. I understand that I am required to make and maintain records, as required by applicable laws, regulations, rules and policies, included but not limited to fiscal records, medical records, and records related to civil rights issues, which fully demonstrate the extent, nature and medical necessity of services and items provided to recipients, which support the fee charged or payment sought for the services and items, and which demonstrate compliance with all applicable requirements. I understand that I am required to retain these records for five (5) years, and shall make them available on request by an authorized representative of the DSS/MMAC or the U.S. Department of Health and Human Services. I further understand that the retained documents must include all records and documents required by applicable regulations and Medicaid manual and bulletin provisions including the original enrollment documents confirming the provider's original signature. I acknowledge that all services billed through the Medicaid Program are subject to post-payment review, and that this may include unannounced on-site review of records. My failure to submit or failure to retain documentation for all services billed to the Medicaid Program may result in recovery of payments for Medicaid services and may result in sanctions to the provider's Medicaid participation;
7. I understand that either party to this Agreement may terminate my participation in Medicaid under this agreement upon written notice mailed to either my most recent address recorded in the Medicaid enrollment files or the DSS/MMAC. The written notice shall state the reason(s) for the termination. Such reason(s) could include that I am in violation of (a) this agreement, (b) Medicaid claim

certification statement, (c) rules, regulations, policies or procedures of the DSS/MMAC, or (d) State or Local Regulations or Laws which also apply (e.g. fire codes and health codes). All corporations must be registered with the Secretary of State, Corporate Division, and be certified in good standing. I understand that I must be in compliance with all other applicable state or federal laws or regulations. Violation of any law or regulation may result in this agreement being terminated immediately upon mailing of the written notice from the DSS/MMAC; and

8. If at any time state or federally appropriated funds available to the DSS/MMAC for payment to me for covered services under this agreement are insufficient to pay the full amount due, I agree to accept payments reduced in proportion to the funding deficiency.
9. I agree that if I currently provide services or provide services in the future as part of a Rural Health Clinic (RHC), I will deliver and bill Medicaid ONLY for NON-RHC services under my individual or clinic Medicaid provider number. I will maintain a list of on-site services and a contract with the RHC which specifies off-site services that will be provided under my private or clinic practice. A list of costs associated with these services will be maintained and will be provided to the State Medicaid agency upon request. I will not include these services and the associated costs in the RHC cost report. If I am an Independent Provider-Based RHC, I will include a copy of the list of on-site services and contracts in the RHC cost report according to State Regulation 13 CSR 70-94.010, or 13 CSR 70-94.020 if I am a Provider-Based RHC.
10. I understand that even though I do not bill to Medicaid, if I order, prescribe, or refer for Medicaid services this agreement pertains to me as a provider.

I have read and accept the conditions of participation of the Title XIX Participation Agreement for Medicaid Services. I understand that knowingly falsifying or willfully withholding information may be cause for termination of participation in the Missouri Medicaid Program.

I hereby certify that all of the information provided on this application is true and correct, and that the enrolling provider is in compliance with all applicable federal and state laws and regulations. I further certify that neither I, nor any of the enrolling providers, employees, partners, officers, or shareholders owning at least five percent (5%) of said provider are currently barred, suspended, terminated, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from participation in the Medicaid or Medicare programs, nor are any of the above currently under sanction for, or serving a sentence for conviction of any Medicaid or Medicare program violations. I further certify that none of the above are currently sanctioned by any federal agency for any reason other than disclosed herein. I authorize the DSS/MMAC to verify the information provided on this application with other state and federal agencies.

ORIGINAL SIGNATURE OF AUTHORIZED SIGNER (STAMP OR OTHER FACSIMILE IS NOT ACCEPTABLE) The authorized signer of this document verifies that he/she is the enrolling individual provider; or for healthcare organizations, a representative of the provider duly authorized as an agent to execute the agreement on behalf of the Provider under authority granted by said Provider.

Typed or Printed name of Provider or Authorized Representative: _____

Original Signature of Provider or Authorized Representative: _____ **Date Signed** _____

Agency Name _____

MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT AND COMPLIANCE UNIT

BUSINESS ORGANIZATIONAL STRUCTURE

PLEASE TYPE OR PRINT CLEARLY

LEGAL PROVIDER NAME AS FILED WITH THE SECRETARY OF STATE, INCLUDING DBA NAME (Sole Proprietors: Include Name and DBA name)

Legal Name including DBA:	NPI

If you are changing, adding, or deleting information, check the applicable box, furnish the effective date, and complete all the appropriate following section(s).

◯ **NEW EFFECTIVE:** ◯ **UPDATE (add/change/delete) EFFECTIVE:** ◯ **REVALIDATE EFFECTIVE:** ◯ **CHANGE OF OWNERSHIP (CHOW) EFFECTIVE:**

- **Attach the documents as indicated for the completed section**
- ***Complete ONLY ONE of the following sections (I, II, III, IV or V)***
- **Attach additional sheets, if necessary**
- **Manager or owner signature required on page 3**

SECTION I: SOLE PROPRIETOR

↳ Attach the following:
- Registration of Fictitious Name (if applicable)

The legal business name must match the IRS Employee Identification Number letter, the same person can be listed as both owner and managing employee.

PART I – OWNER

OWNER'S NAME		
DATE OF BIRTH	SOCIAL SECURITY NUMBER	EIN
ADDRESS	CITY	
STATE	ZIP	

PART 2 – MANAGING EMPLOYEE(S)

NAME	
DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS	CITY
STATE	ZIP

SECTION II: PARTNERSHIP

↳ Attach Registration of Fictitious Name (if applicable) and Partnership Agreement

NAME		NAME	
DATE OF BIRTH	SOCIAL SECURITY NUMBER / EIN	DATE OF BIRTH	SOCIAL SECURITY NUMBER / EIN
ADDRESS	CITY	ADDRESS	CITY
STATE	ZIP	STATE	ZIP
GENERAL INTEREST IN PARTNERSHIP %		GENERAL INTEREST IN PARTNERSHIP %	
NAME		NAME	
DATE OF BIRTH	SOCIAL SECURITY NUMBER / EIN	DATE OF BIRTH	SOCIAL SECURITY NUMBER / EIN
ADDRESS	CITY	ADDRESS	CITY
STATE	ZIP	STATE	ZIP
GENERAL INTEREST IN PARTNERSHIP %		GENERAL INTEREST IN PARTNERSHIP %	

SECTION III: CORPORATION

◯ For Profit ◯ Not For Profit

↳ Attach the following:

- Articles of Incorporation;
- Current Certificate of Good Standing; and
- Registration of Fictitious Name (if applicable)

PART I – OFFICERS (Attach additional sheets, if necessary)

PRESIDENT		VICE PRESIDENT	
DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS	CITY	ADDRESS	CITY
STATE	ZIP	STATE	ZIP
SECRETARY		TREASURER	
DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS	CITY	ADDRESS	CITY
STATE	ZIP	STATE	ZIP

PART II – DIRECTORS (Attach additional sheets, if necessary)

NAME		NAME	
DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS	CITY	ADDRESS	CITY
STATE	ZIP	STATE	ZIP

PART III – MANAGING EMPLOYEES (Attach additional sheets, if necessary)

NAME		NAME	
DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS	CITY	ADDRESS	CITY
STATE	ZIP	STATE	ZIP

PART IV – STOCKHOLDERS **(N/A FOR NON-PROFIT)** (Attach additional sheets, if necessary)

NAME		NAME	
DATE OF BIRTH	SOCIAL SECURITY NUMBER / EIN	DATE OF BIRTH	SOCIAL SECURITY NUMBER / EIN
ADDRESS	CITY	ADDRESS	CITY
STATE	ZIP	STATE	ZIP
PERCENTAGE OF STOCK HELD %		PERCENTAGE OF STOCK HELD %	
NAME		NAME	
DATE OF BIRTH	SOCIAL SECURITY NUMBER / EIN	DATE OF BIRTH	SOCIAL SECURITY NUMBER / EIN
ADDRESS	CITY	ADDRESS	CITY
STATE	ZIP	STATE	ZIP
PERCENTAGE OF STOCK HELD %		PERCENTAGE OF STOCK HELD %	

SECTION IV: LIMITED LIABILITY COMPANY

Check the LLC's federal income tax reporting status: ◯ SOLE MEMBER ◯ MULTIPLE MEMBERS

↳Attach the following:

- Current Certificate of Good Standing;
- Articles of Organization;
- LLC Operating Agreement;
- LLC Management Agreement (if applicable); and
- Registration of Fictitious Name (if applicable)

The managers and members listed must agree with the IRS Employee Identification Number letter, the operating agreement and the Management Agreement (if applicable). The same person/people can be listed as both manager(s) and member(s).

PART I – MANAGERS AND EXECUTIVE OFFICERS (Attach additional sheets, if necessary)

NAME		NAME	
DATE OF BIRTH	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS	CITY	ADDRESS	CITY
STATE	ZIP	STATE	ZIP

PART II – MEMBERS (Attach additional sheets, if necessary)

NAME		NAME	
DATE OF BIRTH	SOCIAL SECURITY NUMBER / EIN	DATE OF BIRTH	SOCIAL SECURITY NUMBER / EIN
ADDRESS	CITY	ADDRESS	CITY
STATE	ZIP	STATE	ZIP
PERCENTAGE OF OWNERSHIP %		PERCENTAGE OF OWNERSHIP %	

SECTION V: PUBLIC ENTITY- CITY, COUNTY, OR STATE ENTITY

City or county: attach a list of managing employees with name, address, SSN, and DOB information.

State: Attach a confirmation that all managing employees are employees of the State of Missouri. If a contractor is administrating the services, complete a separate Business Organizational Structure form for the contractor.

SECTION VI: LEGAL DISCLOSURE- MANDATORY FOR ALL BUSINESS TYPES

I have read 13 CSR 65-2.010 (25) and 13 CSR 65-2.010 (40), the regulations defining the terms “managing employee” and “owner” for the purposes Missouri Medicaid, and I have listed all individuals and/or business entities that meet either definition.

◯ YES ◯ NO

Has the enrolling entity above, or any managing employee or owner, under any current or former name or business identity, ever had a final adverse legal action, either criminal or civil or regulatory sanction, imposed against it?

◯ YES ◯ NO

If YES, report each final adverse legal action, when it occurred, the Federal or State Agency or the court/administrative body that imposed the action, and the resolution, if any, on separate pages. Attach a copy of the final adverse legal action documentation and resolution.

Contact Name:	
Contact email address:	**Contact phone #:**

SIGNATURE

In Affirmation thereof, the facts stated above are true and correct: (The undersigned understands that false statements made in this filing are subject to the penalties provided under Section 575.040, RSMo)

AUTHORIZED PROVIDER SIGNATURE(form will not be accepted without a dated signature from a managing employee or owner that is listed on this form)		DATE
Typed or printed name of signer:	**Signature:**	