MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT AND COMPLIANCE UNIT

PROVIDER VOLUNTARY TERMINATION REQUEST

A separate form must be submitted for each provider type and/or individual/group. All Sections MUST be completed and the form must be signed. Include the effective date where indicated. Failure to follow these instructions could result in the denial of your request.

SECTION I: PROVIDER INFORMATION – Fill in applicable fields with provider's current information.

FOR **INDIVIDUAL'S** ONLY: LAST NAME	FIRST NAME	MIDDLE INITIAL	SUFFIX

FOR **AGENCIES** ONLY: PROVIDER NAME	DBA (if applicable)
NATIONAL PROVIDER IDENTIFIER (NPI)	TAXONOMY CODE

SECTION II: CONTACT PERSON – Person that can discuss the requested termination and where notification can be sent.

NAME	TELEPHONE / -	E-MAIL ADDRESS

SECTION III: CHANGE REQUEST – Please provide an updated address.

☐ CURRENT ADDRESS ☐ EDIT EFFECTIVE: / /

ADDRESS CITY STATE ZIP CODE

☐ VOLUNTARILY TERMINATE MEDICAID ENROLLMENT EFFECTIVE: / /

SECTION IV: REASON FOR VOLUNTARY TERMINATION REQUEST/COMMENTS

SECTION V: FUTURE RECORD RETENTION INFORMATION – RECORDS MUST BE STORED FOR 5 YEARS AFTER THE TERMINATION DATE ABOVE (7 YEARS FOR NURSING HOME, CSTAR AND COMMUNITY PSYCHIATRIC REHABILITATION PROGRAMS):

LOCATION WHERE RECORDS WILL BE STORED:

ADDRESS: CITY: STATE: ZIP CODE:

FUTURE CONTACT PERSON NAME:

FUTURE CONTACT PHONE:

FUTURE CONTACT E-MAIL:

PROVIDER OR INDIVIDUAL NAME FROM SECTION I	NPI NUMBER

MUST BE SIGNED BY PROVIDER

(Signature) DATE / /

TYPE OR PRINT NAME TYPE OR PRINT TITLE

FAX or EMAIL COMPLETED FORM AND ANY REQUIRED DOCUMENTS TO

573/526-2054

MMAC.Terminations@dss.mo.gov

MMAC USE ONLY

The requested change(s) has been: ☐ PROCESSED ☐ DENIED

REASON FOR DENIAL

PROCESSED BY	DATE / /

(04/18)