MISSOURI DEPARTMENT OF SOCIAL SERVICES (DSS)
MO HEALTHNET DIVISION (MHD)

AUTHORIZATION BY CLINIC/GROUP MEMBERS (Direct Deposit, or Provider Address, or Payment Change)

CLINIC/GROUP NAME	CLINIC/GROUP PROVIDER NPI

ORIGINAL Signature of Authorized Representative	Title of Person Signing	Date Signed

I am the individual authorized to request direct deposit or change in direct deposit, or provider address, or payment change on behalf of all individuals listed below (including additional pages). I acknowledge that each individual has been informed of this request and that the payment due to this clinic/group will be direct deposited to the specified account. This form must be signed by the person with fiscal responsibility for the clinic/group listed below (including additional pages).This form must be submitted with the Application for Provider Direct Deposit and the same person must sign **both forms**, the Application for Provider Direct Deposit **and** the Authorization by Clinic Members.

EACH individual provider employed at the clinic/group must be listed on the Authorization by Clinic/Group Members before direct deposit can be approved, or a provider address or payment change will be processed for the clinic/group provider identifier and individual members. **All other provider types *MUST*** complete an Application for Provider Direct Deposit (for each provider identifier assigned) containing their provider identifier and ***original*** signature and/or an updated provider application containing their provider identifier and original signature for provider address or payment changes. This form may be copied **before** names and signatures are filled in if additional lines are needed to include all members of the clinic/group. A separate Application for Provider Direct Deposit and Authorization by Clinic/Group Members must be completed for each clinic/group provider identifier assigned.

INDIVIDUAL PROVIDERS WITH CLINIC/GROUP

(TYPE or PRINT each provider name and individual provider identifier; please use medium BLACK ink.)

PROVIDER IDENTIFIER	PROVIDER TAXONOMY CODE	PROVIDER NAME	PROVIDER IDENTIFIER	PROVIDER TAXONOMY CODE	PROVIDER NAME

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INDIVIDUAL PROVIDERS WITH CLINIC/GROUP (Page 2)

(TYPE or PRINT each provider name and individual provider identifier; please use medium BLACK ink.)

PROVIDER IDENTIFIER	PROVIDER TAXONOMY CODE	PROVIDER NAME	PROVIDER IDENTIFIER	PROVIDER TAXONOMY CODE	PROVIDER NAME