# Missouri Dental Provider
## Medicaid Enrollment Guide

# Getting Started

*Here's five things you need to know.*

1. The online application must be completed with **Mozilla Firefox** or **Internet Explorer**.
2. Save and return is **only available upon the completion of each full page**.
3. Once submitted, wait two days, and **verify receipt of full application** with MMAC. (They won't notify you if it's not complete.)
4. Using your NPI, you can **email application inquiries and questions** to MMAC.providerenrollment@dss.mo.gov
5. If application is complete, your enrollment **should take about two weeks.**

*Contact the help desk with technical issues at 573-635-3559.*

# Dental Provider Application

*First steps in the enrollment process.*

1. Visit mmac.mo.gov/providers/provider-enrollment/new-providers/.
2. Next select Apply to be a Missouri Medicaid Provider.
3. Review notices and instructions before selecting 'Continue' at the bottom.
4. Now, select 'NEW Provider Enrollment Applications'.
5. Drop Down List and **Select '40 – Dentist' or '50 – Clinic' if you're enrolling as a group or entity**
6. Your personal or entity enrollment status will affect how you complete the application.
7. The next slide will direct you to the appropriate steps.

*Contact the help desk with technical issues at 573-635-3559.*

# Directions by Provider Status

*Choose an option below based on your personal or entity enrollment status*

1. Application Steps for Dentist working with Enrolled Group
2. Application Steps for Dentist Enrolling with SSN
3. Application Steps for Dentist with Non-Enrolled Group
4. Application Steps for New Entity Enrolling for Medicaid

Missouri Coalition for Oral Health

MO Medicaid MATTERS

# Application Steps for Dentists

## Working with an Enrolled Group

# Dentists Working with Enrolled Group

*Instructions and help text for questions 1-15A.*

**Provider Type 40-Dentist**

1. Provider Name (Last, First, MI)
   Providers Name: Last, First Middle
2. Business Telephone
   Phone Number of location
3. Provider Address
   Physical Location participants are seen
4. City
   Physical Location participants are seen
5. State
   Physical Location participants are seen
6. Zip Code
   Physical Location participants are seen
7. County
   Physical Location participants are seen
8. Social Security Number:
   Social Security Number of Provider
9. Date of Birth
   Date of Birth of Provider
10. License Number
    Providers Dental License Number
11. Payee Name Registered with IRS (used to report income)
    Legal name of Clinic with IRS

    Doing Business As (DBA) Name (if applicable)
    Doing business name of clinic (if applicable)

    Payee City
    Physical or billing address of clinic
12. Payee Address
    Physical or billing address of clinic

    Payee State
    Physical or billing address of clinic

    Payee Zip Code
    Physical or billing address of clinic
13. Tax ID# or Social Security# as Registered With IRS (used to report income)
    EIN of clinic
14. Practice Type
    1-Individual Provider
15. Specialties
    Providers Specialty
    1. There are multiple lines to
    2. list additional specialties

15a. National Provider Identifier
     Providers Individual NPI Number

Questions 1-10 should be populated with the **provider's personal information**, main location, and the phone number for that location.

Questions 11-13 should be populated with the **clinic's legal name registered with the IRS, dba if applicable, the clinic's physical or billing address, and the clinic's Tax ID.**

Questions 14-15A should be populated with the provider's specialty and NPI. **Question 14 will ALWAYS BE 1 – INDIVIDUAL PRACTICE** as it relates to the enrolling provider.

*Contact the help desk with technical issues at 573-635-3559.*

# Dentists Working with Enrolled Group

*Supporting documentation needed with your application.*

1. Copy of Provider's License
2. DEA/BNDD Registrations (if applicable)
3. Signed Title XIX Participation Agreement
   (Signed by the enrolling provider)
4. Acceptable Forms of Signature:
   - DocuSign
   - Adobe Sign
   - HelloSign
   - Wet Signature
   - FAX or Stamped Signatures are NOT ACCEPTED

*Contact the help desk with technical issues at 573-635-3559.*

# Dentists Working with Enrolled Group

*Submitting your application after completion of online form.*

1. Print and **sign the confirmation page** from your online submission which **includes your confirmation number**. (It can't be processed without this number.)
2. Fax the confirmation page and the following documents to **573- 634-3105 in one transmission**:

- Copy of Provider License or Social Security Card
- Title XIX Participation Agreement
- Business Organizational Structure Form
- EFT Document
- Voided Check or Bank Letter

*Contact the help desk with technical issues at 573-635-3559.*

# Application Steps for Dentists

Enrolling Under their SSN

# Dentists Enrolling Under their SSN

*Instructions and help text for questions 1-15A.*

**Provider Type 40-Dentist**

| | | | |
|---|---|---|---|
| 1. | Provider Name (Last, First, MI)<br>Providers Name: Last, First Middle | 2. | Business Telephone<br>Phone Number of location |
| 3. | Provider Address<br>Physical Location participants are seen | 4. | City<br>Physical Location participants are seen |
| 5. | State<br>Physical Location participants are seen | 6. | Zip Code<br>Physical Location participants are seen |
| 7. | County<br>Physical Location participants are seen | 8. | Social Security Number:<br>Social Security Number of Provider |
| 9. | Date of Birth<br>Date of Birth of Provider | 10. | License Number<br>Providers Dental License Number |
| 11. | Payee Name Registered with IRS (used to report income)<br>Providers Legal Name from Social Security Card<br>Doing Business As (DBA) Name (if applicable) | 12. | Payee Address<br>Physical address participants are seen |
| | Payee City<br>Physical address participants are seen | | Payee State<br>Physical address participants are seen<br>Payee Zip Code<br>Physical address participants are seen |
| 13. | Tax ID# or Social Security# as Registered With IRS (used to report income)<br>Social Security Number of Provider | 14. | Practice Type<br>1-Individual Provider |
| 15. | Specialties<br>1. Providers Specialty There are multiple lines to<br>2. list additional specialties | 15a. | National Provider Identifier<br>Providers Individual NPI Number |

Questions 1-10 should be populated with the **provider's personal information**, main location and phone number.

Questions 11-13 should be populated with the **provider's legal matching their Social Security Card, physical address that patients will be seen.**

Questions 14-15A should be populated with the provider's specialty and NPI. **Question 14 will ALWAYS BE 1 – INDIVIDUAL PRACTICE** as it relates to the enrolling provider.

*Contact the help desk with technical issues at 573-635-3559.*

# Dentists Enrolling Under their SSN

*Supporting documentation needed with your application.*

1. Copy of Social Security Card
2. Business Organizational Structure Form
3. Signed Title XIX Participation Agreement
   (Signed by the enrolling provider)
4. Fictitious Name Registration Confirmation from the Secretary of State
   (If you're using a dba)
5. Acceptable Forms of Signature:
   - DocuSign
   - Adobe Sign
   - HelloSign
   - Wet Signature
   - FAX or Stamped Signatures are NOT ACCEPTED

*Contact the help desk with technical issues at 573-635-3559.*

# Dentists Enrolling Under their SSN

*Submitting your application after completion of online form.*

1. Print and **sign the confirmation page** from your online submission which **includes your confirmation number**. (It can't be processed without this number.)
2. Fax the confirmation page and the following documents to **573- 634-3105 in one transmission**:

- Copy of Social Security Card
- Title XIX Participation Agreement
- Business Organizational Structure Form (See Next Slide for Completion Support)
- Fictitious Name Confirmation if Applicable
- EFT Document
- Voided Check or Bank Letter

*Contact the help desk with technical issues at 573-635-3559.*

# Dentists Enrolling with their SSN

*The sections you need to complete on your Business Organizational Structure.*

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 |

Complete page one through SECTION I, then skip down to SECTION VI.

**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: | |

After completing SECTION VI, be sure that your signer is listed on the Business Organizational Structure.

*Contact the help desk with technical issues at 573-635-3559.*

# Application Steps for Dentists

## Enrolling with a Non-Enrolled Group

# Dentists Enrolling with Non-Enrolled Group

*Instructions and help text for questions 1-15A.*

**Provider Type 40-Dentist**

1. Provider Name (Last, First, MI)
Providers Name: Last, First Middle

2. Business Telephone
Phone Number of location

3. Provider Address
Physical Location participants are seen

4. City
Physical Location participants are seen

5. State
Physical Location participants are seen

6. Zip Code
Physical Location participants are seen

7. County
Physical Location participants are seen

8. Social Security Number:
Social Security Number of Provider

9. Date of Birth
Date of Birth of Provider

10. License Number
Providers Dental License Number

11. Payee Name Registered with IRS (used to report income)
Legal name of Clinic with IRS

Doing Business As (DBA) Name (if applicable)
Doing business name of clinic (if applicable)

12. Payee Address
Physical or billing address of clinic

Payee State
Physical or billing address of clinic

Payee City
Physical or billing address of clinic

Payee Zip Code
Physical or billing address of clinic

13. Tax ID# or Social Security# as Registered With IRS (used to report income)
EIN of clinic

14. Practice Type
1-Individual Provider

15. Specialties
1. Providers Specialty
There are multiple lines to
2. list additional specialties

15a. National Provider Identifier
Providers Individual NPI Number

Questions 1-10 should be populated with the **provider's personal information**, main location, and the phone number for that location.

Questions 11-13 should be populated with the **clinic's legal name registered with the IRS, dba if applicable, the clinic's physical or billing address, and the clinic's Tax ID.**

Questions 14-15A should be populated with the provider's specialty and NPI. **Question 14 will ALWAYS BE 1 – INDIVIDUAL PRACTICE** as it relates to the enrolling provider.

*Contact the help desk with technical issues at 573-635-3559.*

# Dentists Enrolling with a Non-Enrolled Group

*Supporting documentation needed with your application.*

1. Signed Title XIX Participation Agreement
   (Signed by the enrolling provider)
2. A **preprinted copy of one of the following IRS Documents** with Legal Name and Tax ID:
   - CP 575 or 147C Letter
   - Letter from the IRS with your Tax ID and Legal Name
   - Any IRS Document that contains preprinted legal name and Tax ID
   - **W-9s or 941 Forms are not acceptable proof** of Legal Name and Tax ID
3. **Operating Agreement** that details the terms of the business according the specific needs of the owners and outlines the financial and functional decision-making.
4. **Organizational Chart** with a visual representation of the company's internal structure detailing roles, responsibilities and relationships with the entity.

*Contact the help desk with technical issues at 573-635-3559.*

# Dentists Enrolling with a Non-Enrolled Group

*Submitting your application after completion of online form.*

1. Print and **sign the confirmation page** from your online submission which **includes your confirmation number**. (It can't be processed without this number.)
2. Fax the confirmation page and the following documents to **573- 634-3105 in one transmission**:

- Title XIX Participation Agreement
- Business Organizational Structure Form (See Next Slide for Completion Support)
- EFT Document
- Operating Agreement
- Organizational Chart
- Voided Check or Bank Letter

*Contact the help desk with technical issues at 573-635-3559.*

# Dentists Enrolling with a Non-Enrolled Group

*The sections you need to complete on your 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 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- Not Required for Sole Member LLC;
- 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 IV- Part 1: Managers and Part 2: Members

**List of all Managing Members and Board Members with 5% or more ownership** including names, dates of birth and SSNs. Attach a word document if needed.

After completing the top section, skip down to SECTION IV **if you're enrolling with an LLC, not enrolled with MMAC**.

**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: | |

After completing SECTION IV, be sure that your signer is listed on the Business Organizational Structure.

# Application Steps for an Entity

Enrollment for Medicaid Services

# Entity Enrolling for Medicaid Services

*Instructions and help text for questions 1-15A.*

**Provider Type** 50-Clinic

1. Provider Name (Last, First, MI)
Legal name of Clinic with IRS

2. Business Telephone
Phone Number of location

3. Provider Address
Physical Location participants are seen

4. City
Physical Location participants are seen

5. State
Physical Location participants are seen

6. Zip Code
Physical Location participants are seen

7. County
Physical Location participants are seen

8. Social Security Number:
BLANK or N/A

9. Date of Birth
BLANK or N/A

10. License Number
BLANK or N/A

11. Payee Name Registered with IRS (used to report income)
Legal name of Clinic with IRS

12. Payee Address
Physical or billing address of clinic

Doing Business As (DBA) Name (if applicable)
Doing business name of clinic (if applicable)

Payee State
Physical or billing address of clinic

Payee City
Physical or billing address of clinic

Payee Zip Code
Physical or billing address of clinic

13. Tax ID# or Social Security# as Registered With IRS (used to report income)
EIN of clinic

14. Practice Type
2-Partnership, 4-Corportation/LLC,
5-Charitable,
6-City, County, State, Govenrment Owned

15. Specialties
1. Providers Specialty
There are multiple lines to
2. list additional specialties

15a. National Provider Identifier
Providers Individual NPI Number

Questions 1-10 should be populated with the **entities' legal name as registered with the IRS,** main location where services will be provided, and the phone number and fax number for that location.

Questions 11-13 should be populated with the **entities' legal name registered with the IRS, dba if applicable, the entities' physical or billing address, and the entities' Tax ID.**

Questions 14-15A should be populated with the entities' specialty and NPI. **Question 14 will be either 2 –Partnership, 4-Corporation/LLC, 5-Charitable or 6-City, County, State-Government Owned**

*Contact the help desk with technical issues at 573-635-3559.*

# Entity Enrolling for Medicaid Services

*Submitting your application after completion of online form.*

1. Print and **sign the confirmation page** from your online submission which **includes your confirmation number**. (It can't be processed without this number.)
2. Fax the confirmation page and the following documents to **573- 634-3105 in one transmission**:

- Title XIX Participation Agreement
- Business Organizational Structure Form (See Next few Slides for Completion Support)
- EFT Document
- Operating or Partnership Agreement
- Organizational Chart
- Voided Check or Bank Letter
- Medicare Enrollment or Required Application Fee

*Contact the help desk with technical issues at 573-635-3559.*

# Entity Enrolling for Medicaid Services

*The sections you need to complete on your Business Organizational Structure.*

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**

After completing the top section, skip down, and complete the section that applies to your entity, including additional Word documents where needed:

SECTION II – Partnership

SECTION III – Corporation

SECTION IV – Limited Liability Company

SECTION V – Public Entity – City, County, or State

**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: | |

After completing SECTION IV, be sure that your signer is listed on the Business Organizational Structure.

# Entity Enrolling for Medicaid Services

*Supporting documentation needed with your **Partnership application**.*

1. Signed Title XIX Participation Agreement
   (Signed by the enrolling provider)
2. A **preprinted copy of one of the following IRS Documents** with Legal Name and Tax ID:
   - CP 575 or 147C Letter
   - Letter from the IRS with your Tax ID and Legal Name
   - Any IRS Document that contains **preprinted** legal name and Tax ID
   - **W-9s or 941 Forms are not acceptable proof** of Legal Name and Tax ID
3. **Partnership Agreement** that clearly defines goals, activities and responsibilities of each partner.
4. **Organizational Chart** with a visual representation of the company's internal structure detailing roles, responsibilities and relationships with the entity.
5. Medicare Enrollment or Required Application Fee

*Contact the help desk with technical issues at 573-635-3559.*

# Entity Enrolling for Medicaid Services

*Supporting documentation needed with your **Corporation application**.*

1. Signed Title XIX Participation Agreement
   (Signed by the enrolling provider)
2. A **preprinted copy of one of the following IRS Documents** with Legal Name and Tax ID:
   - CP 575 or 147C Letter
   - Letter from the IRS with your Tax ID and Legal Name
   - Any IRS Document that contains **preprinted** legal name and Tax ID
   - **W-9s or 941 Forms are not acceptable proof** of Legal Name and Tax ID
3. **Operating Agreement** that details the terms of the business according the specific needs of the owners and outlines the financial and functional decision-making.
4. **Organizational Chart** with a visual representation of the company's internal structure detailing roles, responsibilities and relationships with the entity.
5. Medicare Enrollment or Required Application Fee

*Contact the help desk with technical issues at 573-635-3559.*

# Entity Enrolling for Medicaid Services

*Supporting documentation needed with your* ***LLC application****.*

1. Signed Title XIX Participation Agreement
   (Signed by the enrolling provider)
2. A **preprinted copy of one of the following IRS Documents** with Legal Name and Tax ID:
   - CP 575 or 147C Letter
   - Letter from the IRS with your Tax ID and Legal Name
   - Any IRS Document that contains **preprinted** legal name and Tax ID
   - **W-9s or 941 Forms are not acceptable proof** of Legal Name and Tax ID
3. **LLC Operating Agreement** that details the terms of the business according the specific needs of the owners and outlines the financial and functional decision-making.
4. **Organizational Chart** with a visual representation of the company's internal structure detailing roles, responsibilities and relationships with the entity.
5. Medicare Enrollment or Required Application Fee

*Contact the help desk with technical issues at 573-635-3559.*

# Entity Enrolling for Medicaid Services

*Supporting documentation needed with your **Public Entity**.*

1. Signed Title XIX Participation Agreement
   (Signed by the enrolling provider)
2. A **preprinted copy of one of the following IRS Documents** with Legal Name and Tax ID:
   - CP 575 or 147C Letter
   - Letter from the IRS with your Tax ID and Legal Name
   - Any IRS Document that contains **preprinted** legal name and Tax ID
   - **W-9s or 941 Forms are not acceptable proof** of Legal Name and Tax ID
3. **Organizational Chart** with a visual representation of the company's internal structure detailing roles, responsibilities and relationships with the entity.
4. **No Application Fee Required**

*Contact the help desk with technical issues at 573-635-3559.*

# Thank You for Enrolling with Missouri Medicaid

1. Be sure to **verify MMAC's receipt of your full application** by emailing MMAC.providerenrollment@dss.mo.gov with your NPI as reference.
2. Once your full application is received, **expect enrollment to take about two weeks**.
3. Consider **enrolling with the other Managed Care Plans** if you also plan to offer Medicaid services to **disabled populations, pregnant women, and children**.