Provider Enrollment: Dental Providers

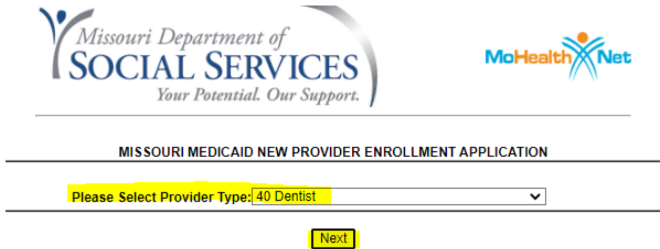
Information and examples on how to complete an enrollment application and how to complete the supporting documentation for enrollment applications

Selecting a Dental Application

- 1. Please go to mmac.mo.gov and select on the right hand side **Enroll as a Provider**

- 2. Scroll down to the blue link (about the middle of the page) and select **Apply to be a Missouri Medicaid Provider**
  - Apply to be a Missouri Medicaid Provider
  - Provider Enrollment Guide (Information and Requirements)
  - Civil Rights (Compliance Information)
  - Home and Community Based Services (Forms and Applications)
  - Provider Enrollment Applications and Forms
- 3. A screen will appear with red lettering at the top, you will scroll to the bottom and click **Continue**
- 4. You will then be directed to a page with 3 options, please choose the first option **NEW Provider Enrollment Applications**

- 5. A drop down menu will appear, please choose **40-DENTIST,** then click **NEXT** and you will be directed to the application



Dental Application

How to complete the application for a Dentist working with an enrolled group

How to complete Questions 1-15A with an enrolled group

Questions 1-10 will need the providers personal information, main location and the phone number for that location

Questions 11-13 will need the clinics information, legal name registered with the IRS and doing business as name (if applicable), physical or billing address for the clinic and tax ID of the clinic

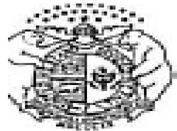
Questions 14-15A will need the providers specialty and NPI, question 14 will always be 1-Individual Provider as it relates to the enrolling provider

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	12.	Payee Address Physical or billing address of clinic
	Doing Business As (DBA) Name (if applicable) Doing business name of clinic (if applicable)		
	Payee City 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 1. Providers Specialty 2. There are multiple lines to list additional specialties	15a.	National Provider Identifier Providers Individual NPI Number

Supporting Documentation: enrolling with a MMAC enrolled Clinic

- Copy of the providers license
- DEA/BNDD information (if applicable)
- Title XIX Participation Agreement signed by the enrolling provider, acceptable for of signature DocuSign, Adobe Sign, Hello Sign and wet signature



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:

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______________________________

Dental Application

How to complete the application and supporting documentation for an individual billing provider enrolling under a their Social Security Number

How to complete Questions 1-15A under your SSN

Questions 1-10 will need the providers personal information, main location and the phone number for that location

Questions 11-13 will need the providers legal name registered from their Social Security Card, physical address the participants will be seen

Questions 14-15A will need the providers specialty and NPI, question 14 will always be 1-Individual Provider as it relates to the enrolling provider

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) Providers Legal Name from Social Security Card Doing Business As (DBA) Name (if applicable)	12.	Payee Address Physical address participants are seen
	Payee City Physical address participants are seen		Payee State Physical address participants are seen Payee Zip Code Physical address participants are seen
13.	Tax ID# or Social Security# as Registered With IRS (used to report income) Social Security Number of Provider	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

Supporting Documents using their SSN

- Title XIX Participation Agreement signed by the enrolling provider
- Copy of their Social Security Card
- Completed Business Organizational Structure (BOS) Form (next slide)
- Voided check or bank letter with the account and routing numbers clearly stated also, completing the below EFT document

MISSOURI DEPARTMENT OF SOCIAL SERVICES (DSS)
MISSOURI MEDICAID AUDIT AND COMPLIANCE (MMAC)
Electronic Funds Transfer (EFT) Authorization Agreement

SECTION 1 – PROVIDER INFORMATION

LEGAL BUSINESS NAME:	DOING BUSINESS AS NAME:
PROVIDER EIN:	PROVIDER NPI:

ARE THERE MULTIPLE ENROLLMENTS UNDER THIS EIN OR NPI? *A separate form must be submitted for each NPI/taxonomy code to be changed.*
NO ☐
YES ☐ - *taxonomy codes effected:*

SECTION 2 – PROVIDER CONTACT INFORMATION

CONTACT PERSON NAME:

PHONE NUMBER:	E-MAIL ADDRESS:

SECTION 3 – FINANCIAL INFORMATION

FINANCIAL INSTITUTION NAME:

ROUTING NUMBER:	ACCOUNT NUMBER:

TYPE OF ACCOUNT: ☐ CHECKING ☐ SAVINGS

SECTION 4 – SUBMISSION INFORMATION

REASON FOR SUBMISSION:
☐ NEW ENROLLMENT – NOT ENROLLED CURRENTLY
☐ CHANGE/UPDATE EFT ONLY
☐ CHANGE IN OWNERSHIP / STRUCTURE – *SUBMIT A PROVIDER UPDATE FORM OR OWNERSHIP REQUEST IN ADDITION TO THIS DOCUMENT*

TYPE OF SUPPORTING DOCUMENT BEING SUBMITTED WITH THIS FORM:
☐ VOIDED CHECK WITH LEGAL OR DBA NAME, ROUTING AND ACCOUNT NUMBERS PREPRINTED ON IT
☐ BANK LETTER THAT LISTS LEGAL OR DBA NAME, ROUTING AND ACCOUNT NUMBERS

SECTION 5 – SIGNATURE AND ACKNOWLEDGEMENT

By completing and submitting this form to the Missouri Medicaid Audit and Compliance Unit (MMAC) for processing, I understand:

1. Payment will be from Federal and State funds and that any falsification or concealment of material fact may be prosecuted under Federal and State laws;
2. The State of Missouri will initiate credit entries (deposits) and will initiate, if necessary, debit entries (withdrawals) or adjustments for any credit entries made in error to my account;
3. The State of Missouri may terminate my enrollment in direct deposit if the State is legally obligated to withhold part or all payments for any reason;
4. MMAC may terminate my enrollment if I no longer meet the eligibility requirements;
5. That this document does not constitute an amendment or assignment of any nature whatsoever of any contract, purchase order or obligation that I may have with any agency of the State of Missouri.

WRITTEN SIGNATURE OF AUTHORIZED INDIVIDUAL	DATE:
PRINTED NAME OF SIGNER:	POSITION HELD WITHIN THE ENTITY NAMED ABOVE:

Supporting Documents using their SSN with a fictitious name

- Title XIX Participation Agreement signed by the enrolling provider
- Copy of their Social Security Card
- Completed Business Organizational Structure (BOS) Form (next slide)
- Fictitious Name registration from the Secretary of State
- Voided check or bank letter with the account and routing numbers clearly stated also, completing the below EFT document

MISSOURI DEPARTMENT OF SOCIAL SERVICES (DSS)
MISSOURI MEDICAID AUDIT AND COMPLIANCE (MMAC)
Electronic Funds Transfer (EFT) Authorization Agreement

SECTION 1 – PROVIDER INFORMATION

LEGAL BUSINESS NAME:	DOING BUSINESS AS NAME:
PROVIDER EIN:	PROVIDER NPI:

ARE THERE MULTIPLE ENROLLMENTS UNDER THIS EIN OR NPI? ***A separate form must be submitted for each NPI/taxonomy code to be changed.***
NO ☐
YES ☐- *taxonomy codes effected:*

SECTION 2 – PROVIDER CONTACT INFORMATION

CONTACT PERSON NAME:

PHONE NUMBER:	E-MAIL ADDRESS:

SECTION 3 – FINANCIAL INFORMATION

FINANCIAL INSTITUTION NAME:

ROUTING NUMBER:	ACCOUNT NUMBER:

TYPE OF ACCOUNT: ☐ CHECKING ☐ SAVINGS

SECTION 4 – SUBMISSION INFORMATION

REASON FOR SUBMISSION:
☐ NEW ENROLLMENT – NOT ENROLLED CURRENTLY
☐ CHANGE/UPDATE EFT ONLY
☐ CHANGE IN OWNERSHIP / STRUCTURE – ***SUBMIT A PROVIDER UPDATE FORM OR OWNERSHIP REQUEST IN ADDITION TO THIS DOCUMENT***

TYPE OF SUPPORTING DOCUMENT BEING SUBMITTED WITH THIS FORM:
☐ VOIDED CHECK WITH LEGAL OR DBA NAME, ROUTING AND ACCOUNT NUMBERS PREPRINTED ON IT
☐ BANK LETTER THAT LISTS LEGAL OR DBA NAME, ROUTING AND ACCOUNT NUMBERS

SECTION 5 – SIGNATURE AND ACKNOWLEDGEMENT

By completing and submitting this form to the Missouri Medicaid Audit and Compliance Unit (MMAC) for processing, I understand:

1. Payment will be from Federal and State funds and that any falsification or concealment of material fact may be prosecuted under Federal and State laws;
2. The State of Missouri will initiate credit entries (deposits) and will initiate, if necessary, debit entries (withdrawals) or adjustments for any credit entries made in error to my account;
3. The State of Missouri may terminate my enrollment in direct deposit if the State is legally obligated to withhold part or all payments for any reason;
4. MMAC may terminate my enrollment if I no longer meet the eligibility requirements;
5. That this document does not constitute an amendment or assignment of any nature whatsoever of any contract, purchase order or obligation that I may have with any agency of the State of Missouri.

WRITTEN SIGNATURE OF AUTHORIZED INDIVIDUAL	DATE:
PRINTED NAME OF SIGNER:	POSITION HELD WITHIN THE ENTITY NAMED ABOVE:

Business Organizational Structure Form (BOS)

Providers Enrolling under their **Social Security Number**

You will need to complete the pictured sections, see picture on the right

Legal name, listed with the IRS, and the NPI including fictitious name

Section I: Sole Proprietor list owner and managing employees name, date of birth and social security number

Section VI: Legal Disclosure-Mandatory for all Business Types

Contact Information: Name, Email and Phone Number

Must be signed and dated by someone listed on the Business Organizational Structure

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 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 Affimation 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:

Dental Application

How to complete the application and supporting documentation for an individual billing provider enrolling under a NON-enrolled group

How to complete Questions 1-15A with a non-enrolled group

Questions 1-10 will need the providers personal information, main location and the phone number for that location

Questions 11-13 will need the clinics information, legal name registered with the IRS and doing business as name (if applicable), physical or billing address for the clinic and tax ID of the clinic

Questions 14-15A will need the providers specialty and NPI, question 14 will always be 1-Individual Provider as it relates to the enrolling provider

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

15a. National Provider Identifier
Providers Individual NPI Number

Business Organizational Structure Form (BOS)

Providers Enrolling with a LLC: **Limited Liability Company** not enrolled with MMAC

You will need to complete the pictured sections, see picture on the right, if more room is needed you can supply a word document for additional information

Legal name, listed with the IRS, and the NPI

Section IV: Limited Liability Company, Part 1: Managers and Part 2: Members

Section IV continued: List of all Managing Members and Board Members with 5% or more Ownership, including a list of names, dates of birth and SSN's using the attached BOS document

Section VI: Legal Disclosure-Mandatory for all Business Types

Contact Information: Name, Email and Phone Number

Must be signed and dated by someone listed on the Business Organizational Structure

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 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:

Supporting Documents with a NON-enrolled Group

- Title XIX Participation Agreement signed by the enrolling provider
- a copy of one of the following IRS documents must be submitted. The legal name and Tax ID number must be **PREPRINTED** on the document by the IRS:
  - CP 575 or 147C letter
  - letter from IRS with the Tax ID number and legal name
  - any IRS document that has the legal name and Tax ID number PREPRINTED on it.
  - NOTE: A W-9 or 941 forms or computer printed forms ARE NOT ACCEPTABLE.
- Operating Agreement that is 10-20 pages to customizes the terms of a business according to the specific needs of the owners, and outlines the financial and functional decision-making in a structured manner
- Organizational Chart: a diagram that visually conveys a company's internal structure by detailing the roles, responsibilities, and relationships between individuals within an entity

Supporting Documents with a NON-enrolled Group

- Completed Business Organizational Structure (BOS) Form (previous slide)
- Voided check or bank letter with the account and routing numbers clearly stated also, completing the below EFT document

MISSOURI DEPARTMENT OF SOCIAL SERVICES (DSS)
MISSOURI MEDICAID AUDIT AND COMPLIANCE (MMAC)
Electronic Funds Transfer (EFT) Authorization Agreement

SECTION 1 – PROVIDER INFORMATION

LEGAL BUSINESS NAME:	DOING BUSINESS AS NAME:
PROVIDER EIN:	PROVIDER NPI:

ARE THERE MULTIPLE ENROLLMENTS UNDER THIS EIN OR NPI? ***A separate form must be submitted for each NPI/taxonomy code to be changed.***
NO ☐
YES ☐- *taxonomy codes effected:*

SECTION 2 – PROVIDER CONTACT INFORMATION

CONTACT PERSON NAME:

PHONE NUMBER:	E-MAIL ADDRESS:

SECTION 3 – FINANCIAL INFORMATION

FINANCIAL INSTITUTION NAME:

ROUTING NUMBER:	ACCOUNT NUMBER:

TYPE OF ACCOUNT: ☐ CHECKING ☐ SAVINGS

SECTION 4 – SUBMISSION INFORMATION

REASON FOR SUBMISSION:
☐ NEW ENROLLMENT – NOT ENROLLED CURRENTLY
☐ CHANGE/UPDATE EFT ONLY
☐ CHANGE IN OWNERSHIP / STRUCTURE – ***SUBMIT A PROVIDER UPDATE FORM OR OWNERSHIP REQUEST IN ADDITION TO THIS DOCUMENT***

TYPE OF SUPPORTING DOCUMENT BEING SUBMITTED WITH THIS FORM:
☐ VOIDED CHECK WITH LEGAL OR DBA NAME, ROUTING AND ACCOUNT NUMBERS PREPRINTED ON IT
☐ BANK LETTER THAT LISTS LEGAL OR DBA NAME, ROUTING AND ACCOUNT NUMBERS

SECTION 5 – SIGNATURE AND ACKNOWLEDGEMENT

By completing and submitting this form to the Missouri Medicaid Audit and Compliance Unit (MMAC) for processing, I understand:

1. Payment will be from Federal and State funds and that any falsification or concealment of material fact may be prosecuted under Federal and State laws;
2. The State of Missouri will initiate credit entries (deposits) and will initiate, if necessary, debit entries (withdrawals) or adjustments for any credit entries made in error to my account;
3. The State of Missouri may terminate my enrollment in direct deposit if the State is legally obligated to withhold part or all payments for any reason;
4. MMAC may terminate my enrollment if I no longer meet the eligibility requirements;
5. That this document does not constitute an amendment or assignment of any nature whatsoever of any contract, purchase order or obligation that I may have with any agency of the State of Missouri.

WRITTEN SIGNATURE OF AUTHORIZED INDIVIDUAL	DATE:
PRINTED NAME OF SIGNER:	POSITION HELD WITHIN THE ENTITY NAMED ABOVE:

Dental Application

How to complete the application and supporting documentation for an entity to enroll for Medicaid Services

How to complete Questions 1-15A for a entity enrollment

Questions 1-10 will need entities legal name registered with the IRS, main location (where services are provided) phone and fax number for that location

Questions 11-13 will need the entities legal name registered with the IRS and doing business as name (if applicable), physical or billing address for the entity and tax ID of the clinic

Questions 14-15A will need the entities specialty and NPI, question 14 will always be either 2-Partnership, 4-Corporation/LLC, 5-Chartiable or 6-City, County, State, Government Owned

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

    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
    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

Business Organizational Structure Form (BOS)

Providers Enrolling as a **Partnership**

You will need to complete the pictured sections, see picture on the right, if more room is needed you can supply a word document for additional information

Legal name, listed with the IRS, and the NPI

Section II: Partnership, list all partners with 5% or more ownership

Section VI: Legal Disclosure-Mandatory for all Business Types

Contact Information: Name, Email and Phone Number

Must be signed and dated by someone listed on the Business Organizational Structure

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 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 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:	

Supporting Documents for Partnership

- Title XIX Participation Agreement signed by the enrolling provider
- a copy of one of the following IRS documents must be submitted. The legal name and Tax ID number must be **PREPRINTED** on the document by the IRS:
  - CP 575 or 147C letter
  - letter from IRS with the Tax ID number and legal name
  - any IRS document that has the legal name and Tax ID number PREPRINTED on it.
  - NOTE: A W-9 or 941 forms or computer printed forms ARE NOT ACCEPTABLE.
- Partnership Agreement: written documents to clearly define specific goals, activities and responsibilities of each partner
- Organizational Chart: a diagram that visually conveys a company's internal structure by detailing the roles, responsibilities, and relationships between individuals within an entity
- Medicare enrollment or application fee required

Business Organizational Structure Form (BOS)

Providers Enrolling as a **Corporation:**

You will need to complete the pictured sections, see picture on the right, if more room is needed you can supply a word document for additional information

Legal name, listed with the IRS, and the NPI

Section III: Corporation chose either Non-Profit or For Profit

Section IV continued: Part 1 & Part 2: For Profit list officers (CEO, CFO etc.) Non-Profit list Board Members (Chairman, Vice Chairman, etc.), additional sheets are allowed, Part 3: Managing Employees, Part IV: Stockholders with percentages (additional sheets allowed)

Section VI: Legal Disclosure-Mandatory for all Business Types

Contact Information: Name, Email and Phone Number

Must be signed and dated by someone listed on the Business Organizational Structure

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 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 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:

Supporting Documents for Corporation

- Title XIX Participation Agreement signed by the enrolling provider
- a copy of one of the following IRS documents must be submitted. The legal name and Tax ID number must be **PREPRINTED** on the document by the IRS:
  - CP 575 or 147C letter
  - letter from IRS with the Tax ID number and legal name
  - any IRS document that has the legal name and Tax ID number PREPRINTED on it.
  - NOTE: A W-9 or 941 forms or computer printed forms ARE NOT ACCEPTABLE.
- Operating Agreement that is 10-20 pages to customizes the terms of a business according to the specific needs of the owners, and outlines the financial and functional decision-making in a structured manner
- Organizational Chart: a diagram that visually conveys a company's internal structure by detailing the roles, responsibilities, and relationships between individuals within an entity
- Medicare enrollment or application fee required

Business Organizational Structure Form (BOS)

Providers Enrolling as a LLC: **Limited Liability Company**

You will need to complete the pictured sections, see picture on the right, if more room is needed you can supply a word document for additional information

Legal name, listed with the IRS, and the NPI

Section IV: Limited Liability Company, Part 1: Managers and Part 2: Members

Section IV continued: List of all Managing Members and Board Members with 5% or more Ownership, including a list of names, dates of birth and SSN's using the attached BOS document

Section VI: Legal Disclosure-Mandatory for all Business Types

Contact Information: Name, Email and Phone Number

Must be signed and dated by someone listed on the Business Organizational Structure

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 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 Affimation 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:	

Supporting Documents for Limited Liability Company

- Title XIX Participation Agreement signed by the enrolling provider
- a copy of one of the following IRS documents must be submitted. The legal name and Tax ID number must be **PREPRINTED** on the document by the IRS:
  - CP 575 or 147C letter
  - letter from IRS with the Tax ID number and legal name
  - any IRS document that has the legal name and Tax ID number PREPRINTED on it.
  - NOTE: A W-9 or 941 forms or computer printed forms ARE NOT ACCEPTABLE.
- LLC Operating Agreement that is 10-20 pages to customizes the terms of a Limited Liability Company (LLC) according to the specific needs of the owners, and outlines the financial and functional decision-making in a structured manner.
- Organizational Chart: a diagram that visually conveys a company's internal structure by detailing the roles, responsibilities, and relationships between individuals within an entity
- Medicare enrollment or application fee required

Business Organizational Structure Form (BOS)

Providers Enrolling as a **Public Entity – City, County or State Entity**

You will need to complete the pictured sections, see picture on the right, if more room is needed you can supply a word document for additional information

Legal name, listed with the IRS, and the NPI

Section V: Public Entity – City, County or State Entity (Must list all managing employees)

Section VI: Legal Disclosure-Mandatory for all Business Types

Contact Information: Name, Email and Phone Number

Must be signed and dated by someone listed on the Business Organizational Structure

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 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:	

Supporting Documents for Public Entity

- Title XIX Participation Agreement signed by the enrolling provider
- a copy of one of the following IRS documents must be submitted. The legal name and Tax ID number must be **PREPRINTED** on the document by the IRS:
  - CP 575 or 147C letter
  - letter from IRS with the Tax ID number and legal name
  - any IRS document that has the legal name and Tax ID number PREPRINTED on it.
  - NOTE: A W-9 or 941 forms or computer printed forms ARE NOT ACCEPTABLE.
- Organizational Chart: a diagram that visually conveys a company's internal structure by detailing the roles, responsibilities, and relationships between individuals within an entity
- **APPLICATION FEE NOT REQUIRED**

Supporting Documents for an entity enrollment

- Completed Business Organizational Structure (BOS) Form (previous slide)
- Voided check or bank letter with the account and routing numbers clearly stated also, completing the below EFT document

MISSOURI DEPARTMENT OF SOCIAL SERVICES (DSS)
MISSOURI MEDICAID AUDIT AND COMPLIANCE (MMAC)
Electronic Funds Transfer (EFT) Authorization Agreement

SECTION 1 – PROVIDER INFORMATION

LEGAL BUSINESS NAME:	DOING BUSINESS AS NAME:
PROVIDER EIN:	PROVIDER NPI:

ARE THERE MULTIPLE ENROLLMENTS UNDER THIS EIN OR NPI? ***A separate form must be submitted for each NPI/taxonomy code to be changed.***
NO ☐
YES ☐- *taxonomy codes effected:*

SECTION 2 – PROVIDER CONTACT INFORMATION

CONTACT PERSON NAME:	
PHONE NUMBER:	E-MAIL ADDRESS:

SECTION 3 – FINANCIAL INFORMATION

FINANCIAL INSTITUTION NAME:	
ROUTING NUMBER:	ACCOUNT NUMBER:

TYPE OF ACCOUNT: ☐ CHECKING ☐ SAVINGS

SECTION 4 – SUBMISSION INFORMATION

REASON FOR SUBMISSION:
☐ NEW ENROLLMENT – NOT ENROLLED CURRENTLY
☐ CHANGE/UPDATE EFT ONLY
☐ CHANGE IN OWNERSHIP / STRUCTURE – ***SUBMIT A PROVIDER UPDATE FORM OR OWNERSHIP REQUEST IN ADDITION TO THIS DOCUMENT***

TYPE OF SUPPORTING DOCUMENT BEING SUBMITTED WITH THIS FORM:
☐ VOIDED CHECK WITH LEGAL OR DBA NAME, ROUTING AND ACCOUNT NUMBERS PREPRINTED ON IT
☐ BANK LETTER THAT LISTS LEGAL OR DBA NAME, ROUTING AND ACCOUNT NUMBERS

SECTION 5 – SIGNATURE AND ACKNOWLEDGEMENT

By completing and submitting this form to the Missouri Medicaid Audit and Compliance Unit (MMAC) for processing, I understand:

1. Payment will be from Federal and State funds and that any falsification or concealment of material fact may be prosecuted under Federal and State laws;
2. The State of Missouri will initiate credit entries (deposits) and will initiate, if necessary, debit entries (withdrawals) or adjustments for any credit entries made in error to my account;
3. The State of Missouri may terminate my enrollment in direct deposit if the State is legally obligated to withhold part or all payments for any reason;
4. MMAC may terminate my enrollment if I no longer meet the eligibility requirements;
5. That this document does not constitute an amendment or assignment of any nature whatsoever of any contract, purchase order or obligation that I may have with any agency of the State of Missouri.

WRITTEN SIGNATURE OF AUTHORIZED INDIVIDUAL	DATE:
PRINTED NAME OF SIGNER:	POSITION HELD WITHIN THE ENTITY NAMED ABOVE:

eMOMED Portal

Use this site for the following:

- Add locations
- Check claims
- Adding and removing Administrators
- eMOMED trainings and assistance
- Quick Links:
  - State of Missouri Website
  - DSS Website
  - DSS/MHD Website
- Revalidations
  - Submitting the revalidation
  - Reviewing any rejections or questions
  - Uploading additional documents for revalidation

Any Questions regarding eMOMED call the help desk (573) 635-3559

ePassport
Home / ePassport

External Links
State of Missouri Web site
Department of Social Services
MO HealthNet Division
- Provider Information
- Provider Enrollment Application
- Participant Information

ePassport News
eNews

07/17/2019
eMOMED Training and Assistance Utilities

03/24/2015
Removing a User's Access to an NPI

03/24/2015
Requesting & Accepting NPI Access

Welcome to ePassport

! *Alerts (1) - Click to hide*

HELP CENTER:
Do you need help adding an NPI to your account as a admin or biller? Click the videos below to help you walk through the process:

Adding an NPI as a Provider Employee

Adding an NPI as a Provider Admin/Individual Provider   Accepting an Access Request (for admins)

Do you bill batch and need help coding your file? Click on these helpful links below for help

EDI Companion Guide

HIPAA EDI 5010's Consolidation Guides

Need to setup a Trading Partner Agreement with MoHealthNet? Check out these helpful link below:

NOTE: YOU MUST INCLUDE A VALID eMOMED USER ID FOR YOU TO SUBMIT A TRADING PARTNER WITH MOHEALTHNET

Trading Partner Agreement Form (Batch Users Only)

Completing the Provider Revalidation Application? Check out the videos below.

Provider Revalidation Process

Faxing Supporting Documentation

Welcome to ePassport

Maintain User Profile
Update your personal information, such as your phone numbers or address.

Change Password
Change your login password.