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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

SMHW - WISEWOMAN INFORMATION UPDATE

WEB ADDRESS: www.health.mo.gov/showmehealthywomen

INSTRUCTIONS:

This form is to be completed and submitted at the onset of each fiscal contract year to the SMHW program staff, **and at any time during the year that the information changes.** This information is used to update the SMHW web page, refer clients for services, and disseminate SMHW contract information to contractors.

AGENCY/DOING BUSINESS AS (DBA) NAME			CORPORATE/PARENT COMPANY NAME (IF APPLICABLE)		
STREET ADDRESS			STREET ADDRESS		
CITY	STATE	ZIP + 4 DIGITS	CITY	STATE	ZIP + 4 DIGITS
PUBLIC TELEPHONE NUMBER FOR APPOINTMENTS	FAX NUMBER		TELEPHONE NUMBER	FAX NUMBER	

AGENCY NAME & STREET ADDRESS TO SEND CONTRACT DOCUMENTS
AGENCY NAME
STREET/PO BOX ADDRESS
CITY, STATE, ZIP CODE + 4 DIGITS

SHOW ME HEALTHY WOMEN CONTACT INFORMATION		
ADMINISTRATIVE CONTACT NAME	ADMINISTRATIVE E-MAIL ADDRESS	ADMINISTRATIVE TELEPHONE NUMBER
CLINICAL CONTACT NAME	CLINICAL EMAIL ADDRESS	CLINICAL TELEPHONE NUMBER
BILLING CONTACT NAME	BILLING E-MAIL ADDRESS	BILLING TELEPHONE NUMBER

WISEWOMAN CONTACT INFORMATION (IF APPLICABLE)		
ADMINISTRATIVE CONTACT NAME	ADMINISTRATIVE E-MAIL ADDRESS	ADMINISTRATIVE TELEPHONE NUMBER
CLINICAL CONTACT NAME	CLINICAL EMAIL ADDRESS	CLINICAL TELEPHONE NUMBER
BILLING CONTACT NAME	BILLING E-MAIL ADDRESS	BILLING TELEPHONE NUMBER

LIST SATELLITE SITES (IF APPLICABLE)				
1. SATELLITE SITE NAME	STREET ADDRESS	CITY	STATE	ZIP CODE
1. PUBLIC TELEPHONE NUMBER FOR APPOINTMENTS	CLINICAL CONTACT NAME	CLINICAL CONTACT E-MAIL ADDRESS		
2. SATELLITE SITE NAME	STREET ADDRESS	CITY	STATE	ZIP CODE
2. PUBLIC TELEPHONE NUMBER FOR APPOINTMENTS	CLINICAL CONTACT NAME	CLINICAL CONTACT E-MAIL ADDRESS		
3. SATELLITE SITE NAME	STREET ADDRESS	CITY	STATE	ZIP CODE
3. PUBLIC TELEPHONE NUMBER FOR APPOINTMENTS	CLINICAL CONTACT NAME	CLINICAL CONTACT E-MAIL ADDRESS		
4. SATELLITE SITE NAME	STREET ADDRESS	CITY	STATE	ZIP CODE
4. PUBLIC TELEPHONE NUMBER FOR APPOINTMENTS	CLINICAL CONTACT NAME	CLINICAL CONTACT E-MAIL ADDRESS		
5. SATELLITE SITE NAME	STREET ADDRESS	CITY	STATE	ZIP CODE
5. PUBLIC TELEPHONE NUMBER FOR APPOINTMENTS	CLINICAL CONTACT NAME	CLINICAL CONTACT E-MAIL ADDRESS		

CLINICAL EXAMINERS/LICENSE INFORMATION			
NAME (Clinical Examiner performing screening services)	**TITLE**	**NURSE LICENSE NUMBER** (If NP, include RN and NP license number)	**PHYSICIAN LICENSE NUMBER**
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN: ____________ NP: ____________	PA: ____________ DO: ____________ MD: ____________
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN: ____________ NP: ____________	PA: ____________ DO: ____________ MD: ____________
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN: ____________ NP: ____________	PA: ____________ DO: ____________ MD: ____________
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN: ____________ NP: ____________	PA: ____________ DO: ____________ MD: ____________
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN: ____________ NP: ____________	PA: ____________ DO: ____________ MD: ____________
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN: ____________ NP: ____________	PA: ____________ DO: ____________ MD: ____________
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN: ____________ NP: ____________	PA: ____________ DO: ____________ MD: ____________
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN: ____________ NP: ____________	PA: ____________ DO: ____________ MD: ____________
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN: ____________ NP: ____________	PA: ____________ DO: ____________ MD: ____________
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN: ____________ NP: ____________	PA: ____________ DO: ____________ MD: ____________
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN: ____________ NP: ____________	PA: ____________ DO: ____________ MD: ____________
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN: ____________ NP: ____________	PA: ____________ DO: ____________ MD: ____________

I certify to the best of my knowledge and belief that all information provided is true and accurate. I understand this form will be returned if it is illegible, incomplete, and/or not signed.

SIGNATURE	DATE

PRINTED NAME AND TITLE OF PERSON SIGNING