MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

PARTICIPATION AGREEMENT FOR PROFESSIONAL AND SPECIAL SERVICES PROVIDER

AGREEMENT NUMBER	O.A. VENDOR NUMBER

FUNDING SOURCE

FEDERAL AGENCY NAME	FEDERAL AWARD YEAR	STATE	FEDERAL
N/A	N/A	N/A%	N/A%
FEDERAL AWARD NUMBER		RESEARCH & DEVELOPMENT	SUBJECT TO A-133 REQUIREMENTS
N/A		☐ YES ☒ NO	☐ YES ☒ NO
FEDERAL AWARD NAME		CFDA NUMBER	CFDA TITLE
N/A		N/A	N/A

☒ **If checked, this agreement constitutes a vendor relationship, as defined by OMB Circular A-133, and therefore these funds are not federal awards, and are not subject to the federal audit requirements of OMB Circular A-133. This in no way precludes the Department of Health and Senior Services (hereinafter "Department/State Agency") from performing monitoring, review, or any other procedures deemed necessary by the Department to ensure compliance with the provisions of this agreement.**

1. By signing below the Provider agrees to provide services or goods as needed to Department approved clients.
2. This agreement shall consist of this form, the attached Business Associate Provisions document, and the attached Terms and Conditions document which are incorporated herein by reference.
3. Notwithstanding section 1(c) of the Terms and Conditions the Provider is a Medicare and Medicaid provider which submits cost reports that reflects reduction for non-allowable lobbying expense and as such are in compliance with 31 U.S.C. 1352.
4. Notwithstanding section 3(b) and (c) of the Terms and Conditions this agreement focuses exclusively on providing health care services and as such only associated invoices and copies of medical records will be required to be provided to the Department by the Provider.
5. Notwithstanding section 9(b) of the Terms and Conditions this agreement is not intended to waive any claim to which a hospital would otherwise be entitled to under Missouri law.
6. Notwithstanding section 14(b) of the Terms and Conditions this agreement focuses exclusively on providing health care services and no equipment will be required to be provided to the Department by the provider.
7. The Provider shall comply with the policies and procedures required by the Department in the delivery of services, supplies, appliances or pharmaceuticals and in submitting claims for payment, as described in the Program Billing Guidelines which are incorporated herein as if fully set out. The Department shall provide guidelines to the Provider.
8. Services authorized and resulting charges are subject to review and approval by the Department. Payments for service shall be in accordance with Program Billing guidelines in effect at the time services are provided.
9. The Provider shall make all reasonable efforts to pursue third-party payments for services subject to this agreement, unless otherwise indicated in Program Billing Guidelines. The Department must be notified within sixty (60) days of the Provider's receipt of third-party payment.
10. The Provider shall not require or request payment for authorized services from clients covered by this Agreement. The Provider shall have the express right to bill clients covered under this Agreement for services that are not authorized. Unauthorized services are those for which the Department has not given specific prior authorization. All billings for services provided to approved clients must be submitted to the Department no later than sixty (60) days following the date of services provided except that all bills must be submitted no later than thirty (30) days after the close of the state fiscal year on June 30, of each year.
11. Obligations under this agreement shall be suspended at such time as funds are not available to cover payment for services provided to qualified clients. However, suspension shall not eliminate coverage under this agreement for services which had been approved by the Department and which had already been furnished prior to the date of suspension.
12. This agreement shall be effective on the date of approval by the Department and shall continue in effect until such time as either party invokes termination as set forth in the attached Terms and Conditions document. Following any three-year period during which no services have been provided by the Provider in regard to this agreement, this agreement shall cease.
13. The provider acknowledges that pursuant to the Federal Standards for Privacy of Individually Identifiable Health Information (45 CFR Parts 160 and 164), it is a business associate of the Department's Special Health Care Needs Unit, and it shall comply with the additional Business Associate Provisions document attached hereto and incorporated herein by reference.
14. If the Provider has not already submitted a properly completed State Vendor ACH/EFT Application for deposit into a bank account of the Provider, such Application shall accompany the partially-executed Agreement at the time the Provider returns the Agreement to the Department, as the Department will make payments to the Provider through Electronic Funds Transfer. Payment may be delayed until the ACH/EFT application is completed and approved.

PROVIDER NAME (PLEASE TYPE)	PAYMENT MAILING ADDRESS (STREET, CITY, STATE, ZIP)	
NAME OF AUTHORIZED REPRESENTATIVE		
SIGNATURE OF PROVIDER OR REPRESENTATIVE — DATE	EMAIL-ADDRESS	
FEDERAL TAX I.D. OR SOCIAL SECURITY NO.	STATE LICENSE NO. (IF APPLICABLE)	TELEPHONE NUMBER

TYPE OF PROVIDER

☐ PHYSICIAN (M.D./D.O.) ☐ HOSPITAL ☐ PHARMACY ☐ DENTIST ☐ THERAPIST ☐ OTHER _____

CERTIFIED MINORITY OR WOMEN BUSINESS ENTERPRISE (MBE/WBE): ☐ YES ☐ NO

PROVIDER ENROLLMENT APPROVED

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES, DIVISION OF ADMINISTRATION DIRECTOR OR DESIGNEE	TITLE	DATE
	Director or Designee, Division of Administration	

PARTICIPATION AGREEMENT FOR PROFESSIONAL AND SPECIAL SERVICES PROVIDER DH-74A
INSTRUCTIONS FOR COMPLETION

COMPLETE AS FOLLOWS	
1. AGREEMENT NUMBER	SHCN use only.
2. O.A. VENDOR NUMBER	SHCN use only.
3. FEDERAL AGENCY NAME	SHCN use only.
4. FEDERAL AWARD YEAR	SHCN use only.
5. FEDERAL AWARD NUMBER	SHCN use only.
6. FEDERAL AWARD NAME	SHCN use only.
7. FUNDING SOURCE	SHCN use only.
8. PROVIDER NAME	Enter the complete name of the agency/business.
9. NAME OF AUTHORIZED REPRESENTATIVE	Individual designated by agency
10. SIGNATURE OF PROVIDER OR REPRESENTATIVE	Enter original signature of Provider or Representative.
11. DATE	Enter the date form is completed.
12. FEDERAL TAX I.D. NUMBER OR SOCIAL SECURITY NUMBER	Enter the federal tax identification number or the social security number that the Provider will use to file federal income tax.
13. TYPE OF PROVIDER	Mark the box for Type of Provider if applicable. Write in type if “other”.
14. PAYMENT MAILING ADDRESS	Enter the Provider’s address where payment is to be mailed to. (Street/City/State/Zip)
15. E-MAIL ADDRESS	Enter the E-Mail address of the Provider or Representative.
16. STATE LICENSE NUMBER (IF APPLICABLE)	Enter the agency/individual state license number if applicable.
17. TELEPHONE NUMBER	Enter the phone number of the agency/individual Provider.
18. MINORITY OWNED/OPERATED	Mark the box yes or no if minority owned or operated business.
19. PROVIDER ENROLLMENT APPROVED	SHCN use only. **Do not mark below this section.**

Provider is to retain pink copy of Participation Agreement (DH-74A)