MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SPECIAL HEALTH SERVICES

PROVIDER APPLICATION

1. BUSINESS/AGENCY NAME	2. NATIONAL PROVIDER INDENTIFIER NUMBER (NPI)	3. FEDERAL ID OR SS NUMBER

4. LOCATION ADDRESS (STREET, ETC)	5. City State Zip Code

6. TELEPHONE	7. FAX NUMBER	8. COUNTY
( )	( )	

9. PAYMENT MAILING ADDRESS (IF DIFFERENT FROM LOCATION ADDRESS) (STREET, ETC)	10. PAYMENT TELEPHONE
	( )

11. CITY STATE ZIP CODE	12. COUNTY

13. CONTACT PERSON NAME AND TITLE

14. TELEPHONE	15. FAX NUMBER	16. EMAIL ADDRESS
( )	( )	

17. CONTACT PERSON LOCATION ADDRESS (STREET, ETC)	18. CITY STATE ZIP CODE

19. IS THE BUSINESS/AGENCY A MEDICAID PROVIDER?

- ❑ YES IF YES, ENTER NUMBER _____
- ❑ NO

20. COUNTIES OF SERVICE (INDICATE COUNTIES WHERE YOUR SERVICES ARE AVALIABLE.)

- ❑ ALL COUNTIES
- ❑ ADAIR
- ❑ ANDREW
- ❑ ATCHISON
- ❑ AUDRAIN
- ❑ BARRY
- ❑ BARTON
- ❑ BATES
- ❑ BENTON
- ❑ BOLLINGER
- ❑ BOONE
- ❑ BUCHANAN
- ❑ BUTLER
- ❑ CALDWELL
- ❑ CALLAWAY
- ❑ CAMDEN
- ❑ CAPE GIRAREDEAU
- ❑ CARROLL
- ❑ CARTER
- ❑ CASS
- ❑ CEDAR
- ❑ CHARITON
- ❑ CHRISTIAN
- ❑ CLARK
- ❑ CLAY
- ❑ CLINTON
- ❑ COLE
- ❑ COOPER
- ❑ CRAWFORD
- ❑ DADE
- ❑ DALLAS
- ❑ DAVIESS
- ❑ DEKALB
- ❑ DENT
- ❑ DOUGLAS
- ❑ DUNKLIN
- ❑ FRANKLIN
- ❑ GASCONADE
- ❑ GENTRY
- ❑ GREENE
- ❑ GRUNDY
- ❑ HARRISON
- ❑ HENRY
- ❑ HICKORY
- ❑ HOLT
- ❑ HOWARD
- ❑ HOWELL
- ❑ IRON
- ❑ JACKSON
- ❑ JASPER
- ❑ JEFFERSON
- ❑ JOHNSON
- ❑ KNOX
- ❑ LACLEDE
- ❑ LAFAYETTE
- ❑ LAWRENCE
- ❑ LEWIS
- ❑ LINCOLN
- ❑ LINN
- ❑ LIVINGSTON
- ❑ MACON
- ❑ MADISON
- ❑ MARIES
- ❑ MARION
- ❑ MCDONALD
- ❑ MERCER
- ❑ MILLER
- ❑ MISSISSIPPI
- ❑ MONITEAU
- ❑ MONROE
- ❑ MONTGOMERY
- ❑ MORGAN
- ❑ NEW MADRID
- ❑ NEWTON
- ❑ NODAWAY
- ❑ OREGON
- ❑ OSAGE
- ❑ OZARK
- ❑ PEMISCOT
- ❑ PERRY
- ❑ PETTIS
- ❑ PHELPS
- ❑ PIKE
- ❑ PLATTE
- ❑ POLK
- ❑ PULASKI
- ❑ PUTNAM
- ❑ RALLS
- ❑ RANDOLPH
- ❑ RAY
- ❑ REYNOLDS
- ❑ RIPLEY
- ❑ SALINE
- ❑ SCHUYLER
- ❑ SCOTLAND
- ❑ SCOTT
- ❑ SHANNON
- ❑ SHELBY
- ❑ ST CHARLES
- ❑ ST CLAIR
- ❑ ST FRANCOIS
- ❑ ST LOUIS CITY
- ❑ ST LOUIS COUNTY
- ❑ STE GENEVIEVE
- ❑ STODDARD
- ❑ STONE
- ❑ SULLIVAN
- ❑ TANEY
- ❑ TEXAS
- ❑ VERNON
- ❑ WARREN
- ❑ WASHINGTON
- ❑ WAYNE
- ❑ WEBSTER
- ❑ WORTH
- ❑ WRIGHT

21. TYPE OF SERVICES YOU WILL PROVIDE TO ADULT BRAIN INJURY PROGRAM PARTICIPANTS

Complete this section if you wish to provide services for the Adult Brain Injury Program.
Check services you can provide:

- ❑ Adjustment Counseling
- ❑ Neuropsychological Evaluation & Consultation
- ❑ Pre-Vocational/Pre-Employment Training
- ❑ Special Instruction
- ❑ Supported Employment/Follow Along
- ❑ Transitional Home & Community Support

22. TYPE OF SERVICES YOU WILL PROVIDE TO THE CHILDREN AND YOUTH WITH SPECIAL HEALTH CARE NEEDS PROGRAM PARTICIPANTS

Complete this section if you wish to provide services for the Children and Youth with Special Health Care Needs Program.
Check the services you can provide:

Dentistry
- ❑ Endodontics
- ❑ General
- ❑ Oral Surgery
- ❑ Orthodontics
- ❑ Pedodontia
- ❑ Periodontics
- ❑ Prosthodontics

Durable Medical Equipment
- ❑ Augmentative Communication Device & Repair
- ❑ DME Equipment & Repairs
- ❑ Hearing Aid Service & Repairs
- ❑ Orthotics
- ❑ Prosthetics
- ❑ Supplies

Emergency Transportation
- ❑ Emergency Transportation Services

Evaluations & Therapy
- ❑ Audiology
- ❑ Augmentative Communication Evaluation Team
- ❑ Cleft Lip & Palate Management Team
- ❑ Nutrition (Registered Dietitian)
- ❑ Occupational Therapy
- ❑ Physical Therapy
- ❑ Respiratory Therapy
- ❑ Speech Language Pathology/Speech Therapy

Facility Treatment Center
- ❑ Ambulatory Surgery Center
- ❑ Emergency Care Center
- ❑ Hospital Services (Inpatient)
- ❑ Hospital Services (Outpatient)

Interpreter Services
- ❑ Bilingual (list languages)

_____
_____
_____
_____
_____

- ❑ Sign

Pathology
- ❑ Laboratory Services

Pharmacy
- ❑ Pharmacy Services

Physician
- ❑ Anesthesiology
- ❑ Cardiology
- ❑ Cardiology, Pediatric
- ❑ Chiropractic
- ❑ Dermatology
- ❑ Dermatology, Pediatric
- ❑ Emergency Medicine
- ❑ Endocrinology
- ❑ Family Practice
- ❑ Gastroenterology
- ❑ Gastroenterology, Pediatric
- ❑ Genetic (Eval)
- ❑ Hematology
- ❑ Medicine, Internal
- ❑ Medicine, Pediatric Rehabilitation
- ❑ Medicine, Physical and Rehabilitation
- ❑ Nephrology
- ❑ Nephrology, Pediatric
- ❑ Neurology
- ❑ Neurology, Pediatric
- ❑ Ophthalmology
- ❑ Optometry
- ❑ Orthopedic
- ❑ Orthopedic, Pediatric
- ❑ Pathology
- ❑ Pediatrics
- ❑ Pediatrics, Developmental
- ❑ Podiatry
- ❑ Proctology
- ❑ Pulmonary
- ❑ Pulmonary, Pediatric
- ❑ Radiology
- ❑ Rheumatology
- ❑ Rheumatology, Pediatric
- ❑ Surgery, Abdominal
- ❑ Surgery, Cardiovascular
- ❑ Surgery, Colon and Rectal
- ❑ Surgery, Facial Plastic
- ❑ Surgery, General
- ❑ Surgery, Hand
- ❑ Surgery, Head and Neck
- ❑ Surgery, Maxillocranial
- ❑ Surgery, Neurosurgery
- ❑ Surgery, Orthopedic
- ❑ Surgery, Otolaryngology
- ❑ Surgery, Pediatric
- ❑ Surgery, Plastic & Reconstructive
- ❑ Surgery, Thoracic
- ❑ Surgery, Urological
- ❑ Surgery, Vascular
- ❑ Urology

23. CERTIFICATION

By signing this form you are stating that you/your staff are licensed/certified to provide the services that you have selected. Your signature also indicates that you agree to comply with the policies, procedures, and billing guidelines of the program. Failure to abide by these policies and procedures could result in the termination of your contract with the Department of Health and Senior Services and the recovery of funds paid to you for services rendered. You may submit a written request for a copy of the Provider Billing Guidelines.

I CERTIFY THAT THE INFORMATION I PROVIDED IS ACCURATE AND TRUE.	24. SIGNATURE OF APPLICANT/AUTHORIZED REPRESENTATIVE	25. DATE