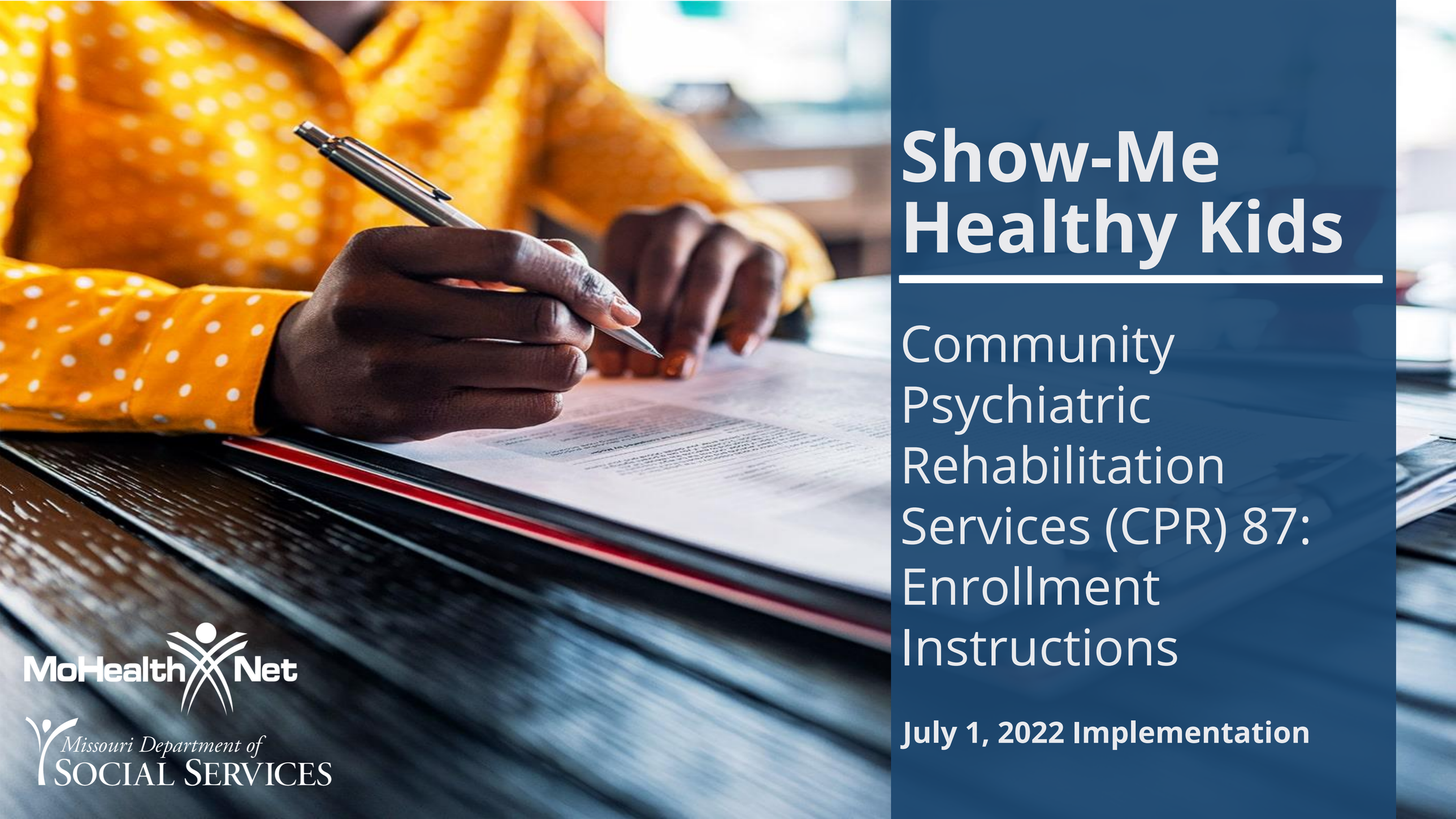


MoHealth Net

Missouri Department of SOCIAL SERVICES

Show-Me Healthy Kids

Community Psychiatric Rehabilitation Services (CPR) 87: Enrollment Instructions

July 1, 2022 Implementation

Agenda

Provider Enrollment Process

- Enrollment Application, Provider Questionnaire, Participation Agreement, and IRS/EIN Verification
- Business Organizational Structure Form
- EFT Documentation, CD Licensure, NPI, and Application Fee

Provider Enrollment Process

Enrollment Application

- **Email** MMAC.providerenrollment@dss.mo.gov to receive your enrollment packet*
- Provider Name
- Contact information
- Disclosure questions related to the Provider, Managing employee, and ownership

*Providers are encouraged to email or call (573) 338-2719 the Missouri Medicaid Audit & Compliance (MMAC) office with questions about enrollment.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT & COMPLIANCE
MO HEALTHNET PROVIDER ENROLLMENT APPLICATION

THIS FORM IS MANDATORY FOR ALL PROVIDERS; READ AND ANSWER ALL QUESTIONS CAREFULLY.

Failure to provide this information is grounds for denial of this application and/or termination of provider participation. A SEPARATE form MUST be completed for each provider identifier. EACH form MUST contain an ORIGINAL SIGNATURE. Answer all questions. Attach an additional sheet to provide complete information for any question. Enrollment inquiries may be directed to Provider Enrollment via e-mail at MMAC.ProviderEnrollment@dss.mo.gov.

Provider's Legal Business Name as listed with IRS and SOS	Doing Business as (DBA) Name – (If applicable)
Provider's Physical Address	Provider's E-mail Address

Contact Person's Name:	Business Phone Number	Business Fax Number

All applying providers must submit a separate Ownership & Disclosure attachment to comply with federal and state Medicaid regulations requiring disclosure of all individuals and/or business organizations that have direct or indirect ownership, management and/or control interests. Those federal and state Medicaid regulations are attached to this application.

In addition to submitting the Ownership & Disclosure attachment, providers may utilize separate documents (i.e. organizational chart, spreadsheet, etc.) to identify individuals and businesses with ownership or control interests and all "managing employees" as defined in 13 CSR 65-2.010(21). Those documents must contain the full name (First, middle, last and suffix Jr., Sr., etc.), date of birth, and social security number of each individual who has 5% or greater direct/indirect ownership, controlling interest, partnership interest; any contractor or subcontractor; managing employees; officers or directors; or the legal business name and federal EIN of any organization(s) having direct or indirect ownership or controlling interest. A current copy of the provider's CMS-855 that includes all this information may be submitted, if one has been completed.

1. Is this application being made as a result of one or more of the following changes? Yes ☐ No ☐

If yes, check all that apply and complete required section below:

Ownership Change ☐ Merger ☐ Asset Change ☐ New clinic formed at same location ☐
Corporate Structure Change ☐ Replacement Facility ☐ Other ☐
If other, explain the change(s):

Former owner's name(s), provider identifier(s), and clinic/facility name(s):

New owner's name and address, clinic/facility names(s):

EFFECTIVE DATE OF CHANGE:

Provider Enrollment Questionnaire

The Provider Enrollment Questionnaire is specific to the provider type.

The Questionnaire requests information such as demographic information, specialty codes, and contact information.

Community Psychiatric Rehabilitation (CPR) Provider Questionnaire

DEPARTMENT OF SOCIAL SERVICES
MISSOURI MEDICAID AUDIT & COMPLIANCE
MISSOURI MEDICAID COMMUNITY PSYCHIATRIC REHABILITATION PROVIDER QUESTIONNAIRE

PLEASE TYPE OR PRINT ALL FORMS IN BLACK INK
ANSWERS ARE REQUIRED FOR ALL QUESTIONS – USE "N/A" OR "NONE" IF APPLICABLE

PROVIDER AGENCY LEGAL NAME, AS REGISTERED WITH THE IRS AND MO SECRETARY OF STATE	
PROVIDER AGENCY DOING BUSINESS AS (DBA) NAME, AS REGISTERED WITH MO SECRETARY OF STATE (if applicable)	
PROVIDER FULL PHYSICAL ADDRESS	
PROVIDER FULL MAILING ADDRESS (for correspondence, remittance advices and tax forms)	
NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	BUSINESS E-MAIL ADDRESS
FEDERAL EMPLOYER IDENTIFICATION NUMBER (EIN) FROM IRS	BUSINESS TELEPHONE NUMBER WITH AREA CODE
BUSINESS FAX NUMBER WITH AREA CODE	
NAME OF PRIMARY CONTACT PERSON	CONTACT PERSON PHONE NUMBER

CHECK TYPE OF PRACTICE
INDIVIDUAL PRACTICE ☐ PARTNERSHIP ☐ CORPORATION (INC, LLC) ☐ CHARTABLE ☐ PRIVATELY OWNED ☐
CITY, MUNICIPAL, COUNTY, DISTRICT, OR STATE OWNED ☐

CIRCLE SPECIALTY CODE(S) TO BE ASSIGNED

42 Psychiatric Rehabilitation (Public)	43 Psychiatric Rehabilitation (Private)	D2 Children's Division Rehab Residential Provider
D5 OHCDS State	D9 Non-Administrative Agent	E3 Children's Therapeutic Day Treatment
RT Residential Treatment	FT Treatment Foster Care	

Participation Agreement

The person who signs the agreements/applications needs to be listed on the Business Organizational Structural (BOS) Form as a managing employee or listed as an owner.

- The credentialer **cannot** sign the agreement.

This is an agreement with Medicaid and the provider is adhering to all rules and regulations.

Both Pages of the Participation Agreement must be submitted.

Participation Agreement

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:

1. I agree that it is my responsibility to access manual materials that are available from DSS/MMAC over the Internet. I will comply with the Medicaid manual, bulletins, rules, and regulations as required by the DSS/MMAC and the United States Department of Health and Human Services in the delivery of services and merchandise and in submitting claims for payment. I understand that in my field of participation I am not entitled to Medicaid reimbursement if I fail to so comply, and that I can be terminated from the program for failure to comply;
2. The rate of reimbursement for services will be based on charges established and determined by the DSS/MMAC Medicaid manual, bulletins, and amendments thereto in accordance with the Vendor Payment Program, and that charges will not exceed those to the general public for the same services;
3. I agree that the selection of an electronic or Internet claim processing method in no way modifies any requirements of the Missouri Medicaid program policies or procedures except those dealing with claim submission. I understand that all data elements required by DSS/MMAC for paper claims are required for claims submitted electronically, and that those claims not meeting required specifications will not be processed. In the event that DSS/MMAC places me on prepayment review , as authorized by State Regulation 13 CSR 70-3.030, or on a closed-end agreement, I agree to submit all claims on paper until notified by DSS/MMAC that electronic or Internet billing can resume;
4. I understand that I cannot collect for Title XIX covered services from the recipient-patient, his or her spouse, parent, guardian, relative or anyone else receiving public assistance, and if any payment is received or assured from any other source on the recipient-patient's account, that amount will be deducted from the claim I filed with Title XIX Medicaid. I also understand that I must report any payment so received after provider payment is made by Title XIX to the DSS/MMAC for appropriate adjustment action;
5. I agree that I and any contractor, employees, or subcontractors of mine, shall comply with all applicable provisions of State and Federal laws and regulations pertaining to nondiscrimination, sexual harassment and equal employment opportunity including, but not limited to, the following laws and regulations and all subsequent amendments thereto:

10. I understand that even though I do not bill to Medicaid, if I order, prescribe, or refer for Medicaid services this agreement pertains to me as a provider.

I have read and accept the conditions of participation of the Title XIX Participation Agreement for Medicaid Services. I understand that knowingly falsifying or willfully withholding information may be cause for termination of participation in the Missouri Medicaid Program.

I hereby certify that all of the information provided on this application is true and correct, and that the enrolling provider is in compliance with all applicable federal and state laws and regulations. I further certify that neither I, nor any of the enrolling providers, employees, partners, officers, or shareholders owning at least five percent (5%) of said provider are currently barred, suspended, terminated, voluntarily withdrawn as part of a settlement agreement, or otherwise excluded from participation in the Medicaid or Medicare programs, nor are any of the above currently under sanction for, or serving a sentence for conviction of any Medicaid or Medicare program violations. I further certify that none of the above are currently sanctioned by any federal agency for any reason other than disclosed herein. I authorize the DSS/MMAC to verify the information provided on this application with other state and federal agencies.

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 _____

Visit the following webpage to access the Participation Agreement form https://mmac.mo.gov/wp-content/uploads/sites/11/2021/04/Revalidation-Title-XIX-Participation-Agreement.pdf

IRS/EIN Verification

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
- 941 Employers Quarterly Federal Tax Return
- 8109 Tax Coupon
- Any IRS document or letter that has the legal name and Tax ID number PREPRINTED on the document

The W-9 or a computer printed form is **Not Acceptable**

Business Organizational Structure Form

Business Organizational Structure (BOS) Form Guidance

- All managing employees and owners must be listed with names, addresses, SSNs, and DOB information.

- Business entities that qualify as owners must be listed with name, address, and EIN information.

- Select the link to access 13 CSR 65-2.010(25) which defines managing employee and 13 CSR 65-2.010(40) which defines ownership
  https://www.sos.mo.gov/cmsimages/adrules/csr/current/13csr/13c65-2.pdf

Section VI: Legal Disclosure

- Must be answered yes or no with case information entered if answering yes.

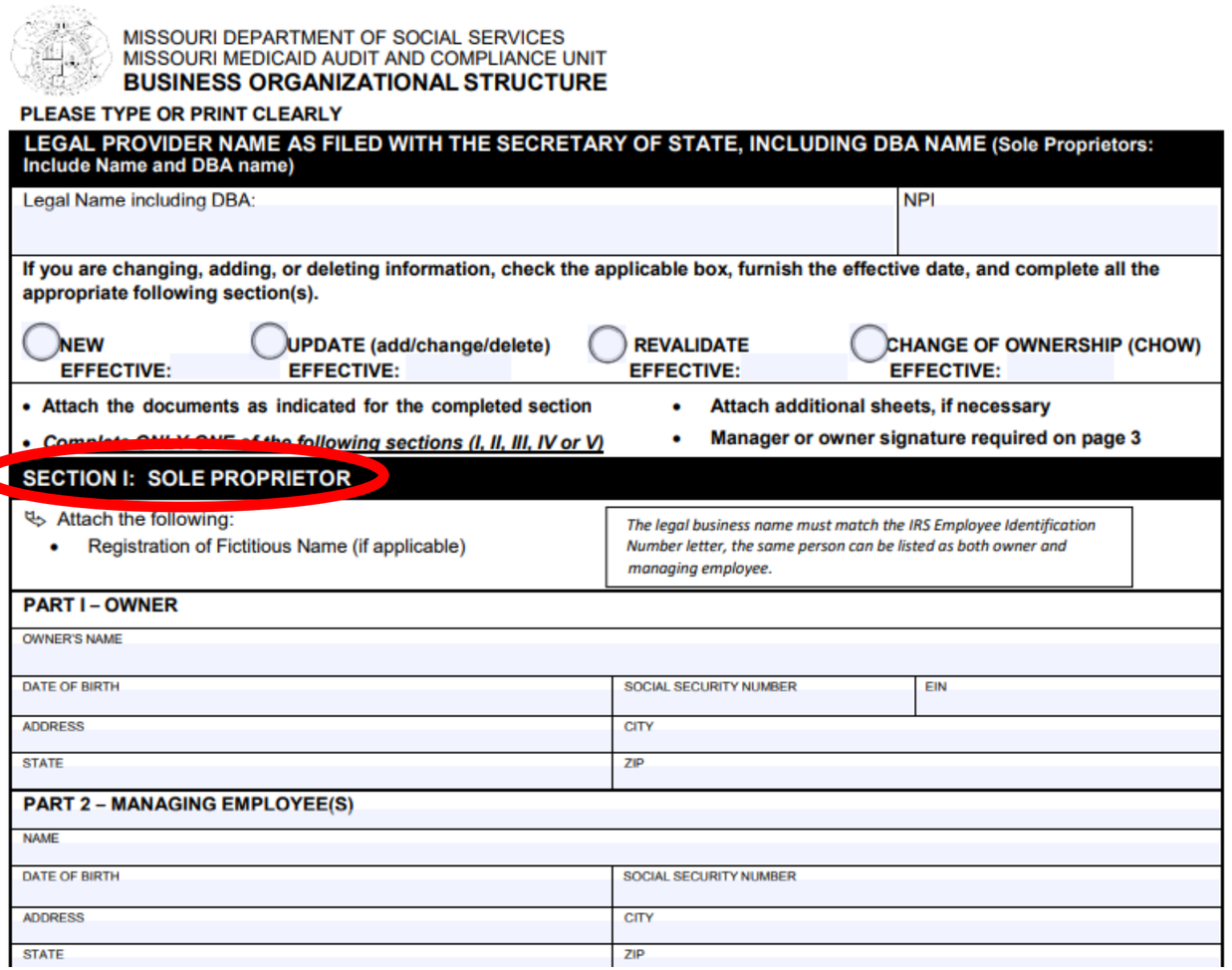
- This document must be hand signed and dated by a managing employee or owner.

Business Organizational Structure Form Guidance cont.

- For each business type additional supporting documents are listed.
- All business types except Sole Proprietors without a DBA are required to register with the Missouri Secretary of State.
- Businesses based in other states are required to register with the Secretary of State where they are located and register with the Missouri Secretary of State as a foreign entity.

Business Organizational Structure – Sole Proprietor

- Visit https://mmac.mo.gov/wp-content/uploads/sites/11/2021/04/BOS-03-2022.pdf to access the BOS form.
- For Sole Proprietor organizations, include names of the business owner and managing employee (if applicable).



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

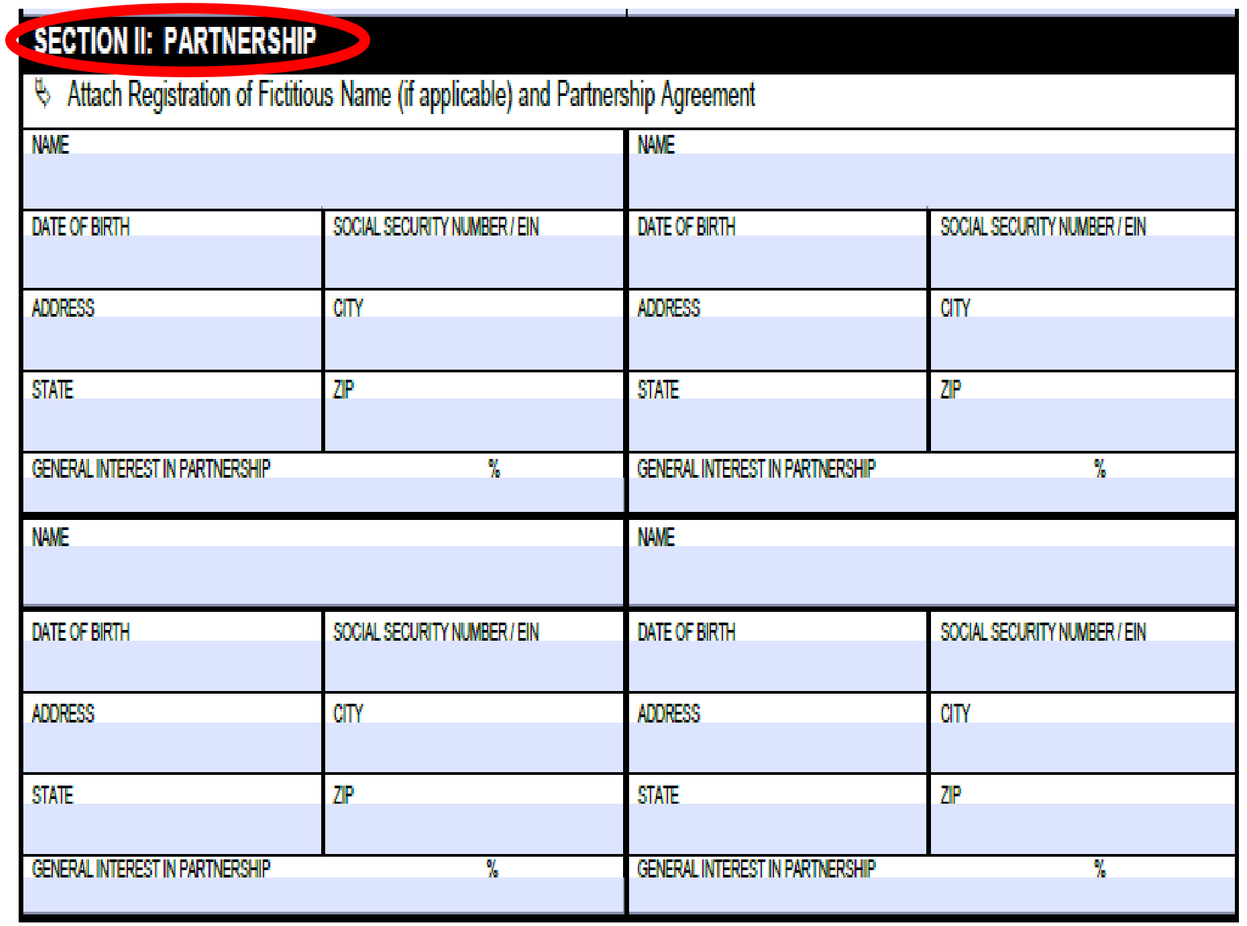
ADDRESS | CITY

STATE | ZIP

Business Organizational Structure – Partnership

Businesses designated as a partnership must include the following:

- List each partner in the partnership
- Identify ownership percentage
- Include the Partnership Agreement



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 %	

Page 1 of 3

Business Organizational Structure – Corporation

For Profit

For Profit Corporations must include information for the following:

Officers Directors

Managing Employees Stockholders

Not for Profit

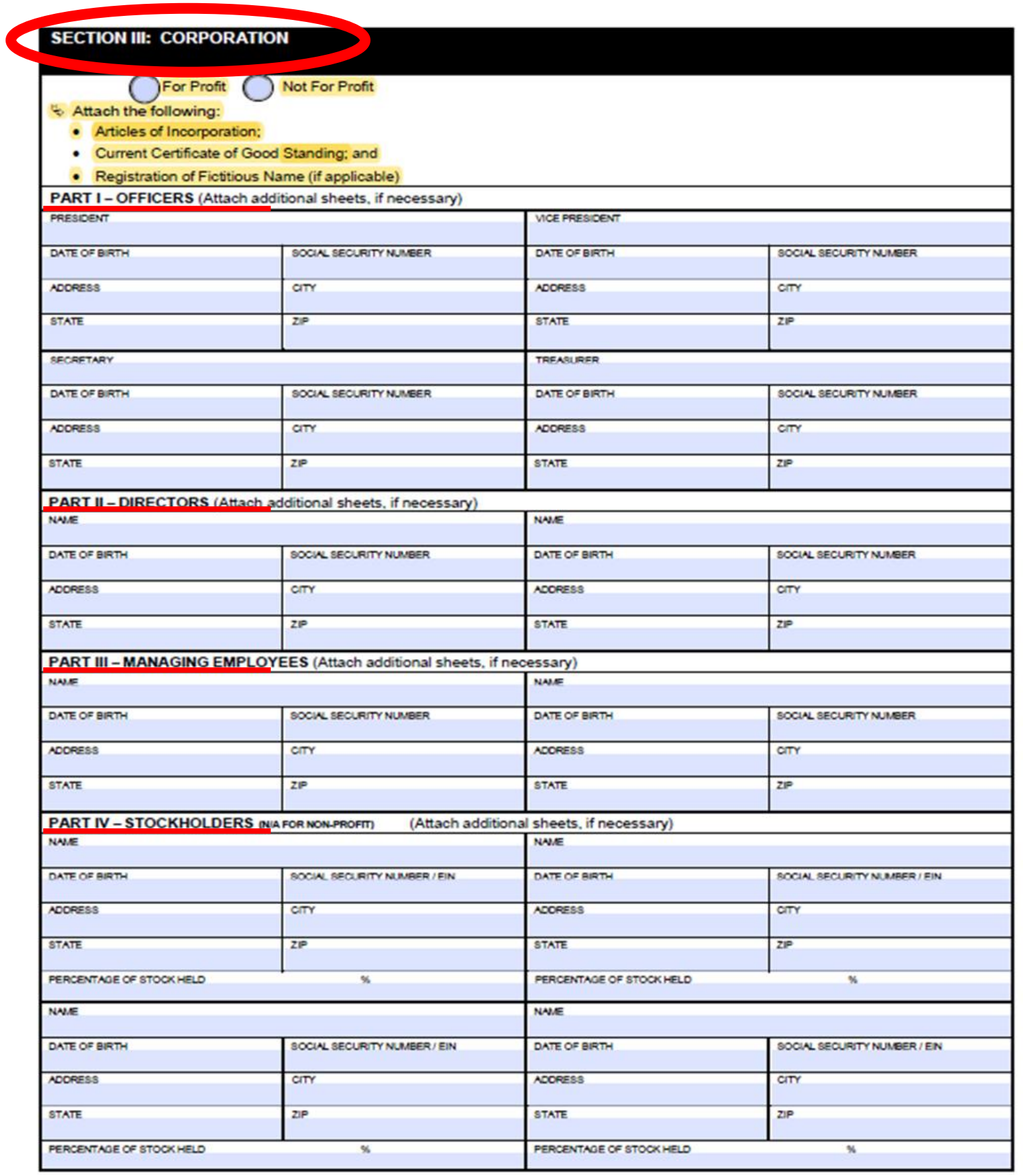
Not for Profit Corporations must include information for the following:

Officers Directors Managing Employees

Attach the following:

- Articles of Incorporation
- Certificate of Good Standing
- Registration of Fictitious Name

Include Ownership Diagram that shows entities & individuals with 5% or more ownership



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	%

Page 2 of 3

Business Organizational Structure – LLC

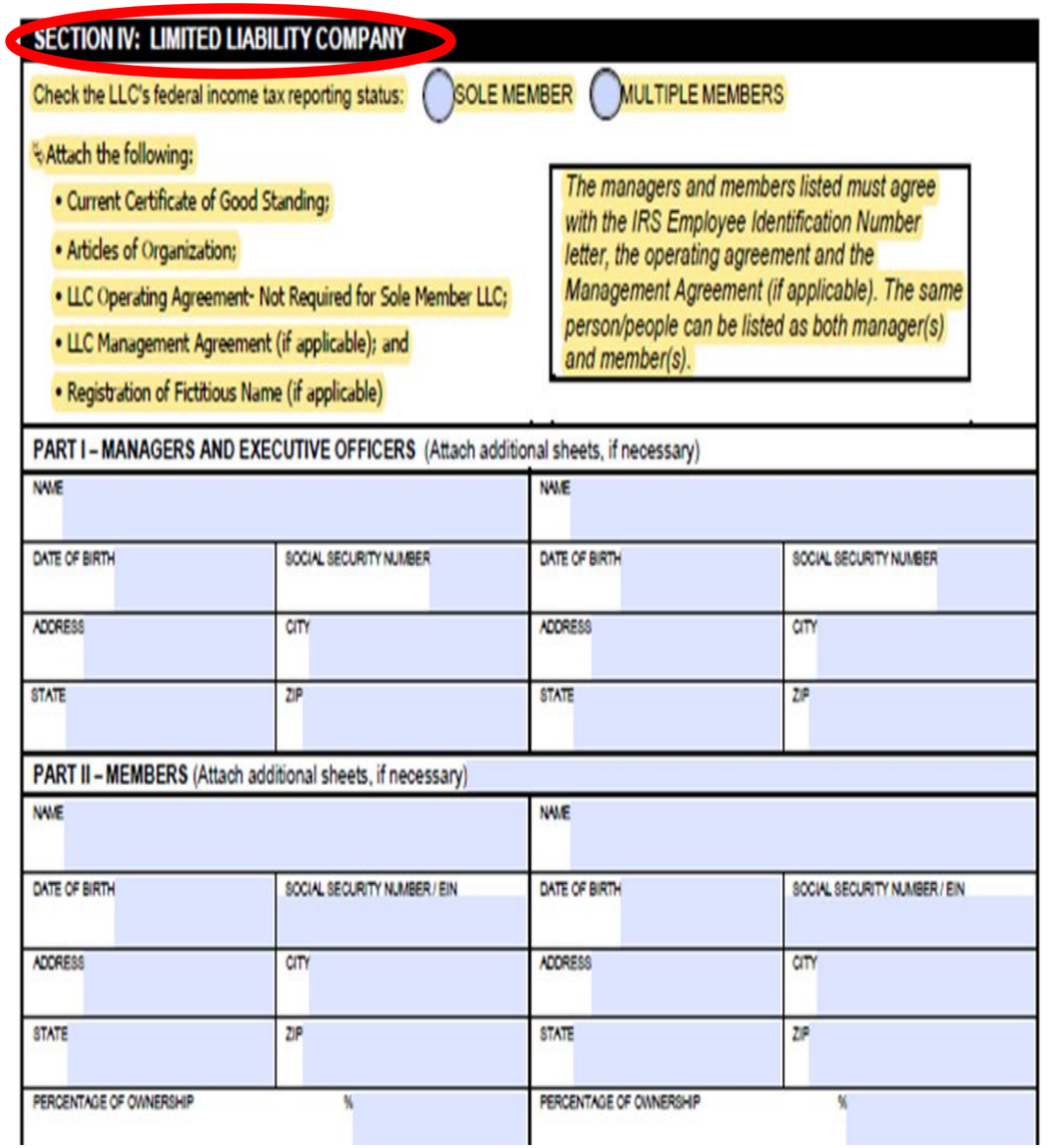
- Identify type of LLC:

  Sole Member Multiple Member

- List all managers, executive officers, and members

- Show percentages of ownership for each member

- Include the following:
  - Good Standing Letter
  - Articles of Organization
  - LLC Operating Agreement
  - Registration of Fictitious Name
  - Ownership Diagram that shows all entity and individuals with 5 % or more of ownership



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 %	

Business Organizational Structure – Public Entity – City, County, State Owned

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.

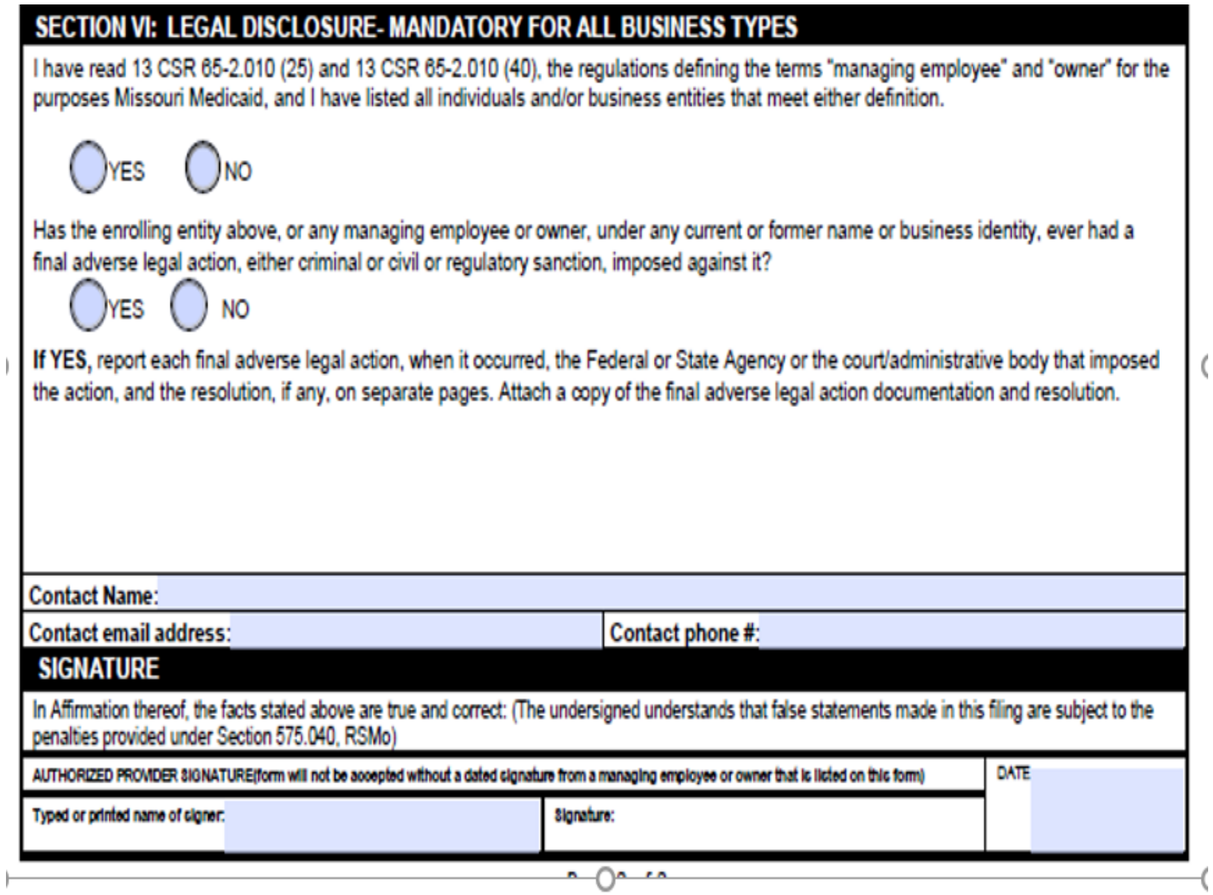
State: Attach a confirmation that all managing employees are employees of the State of Missouri. If a contractor is administrating the services, complete a separate Business Organizational Structure form for the contractor.

If City/County: Include a document with: Managing employee name, title, Social Security number, and Date of Birth.

If State owned: Confirmation that all managing employees are state of Missouri employees. If Contractor is administrating the services a separate BOS must be filled out.

Business Organizational Structure – Legal Disclosure & Signature

- Legal Disclosure question – All Business Types
- Include contact information if answer is **YES**.
- The Business Organizational Structure form must be signed by an Owner, Managing Employee, or Director that is listed on the BOS form.



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

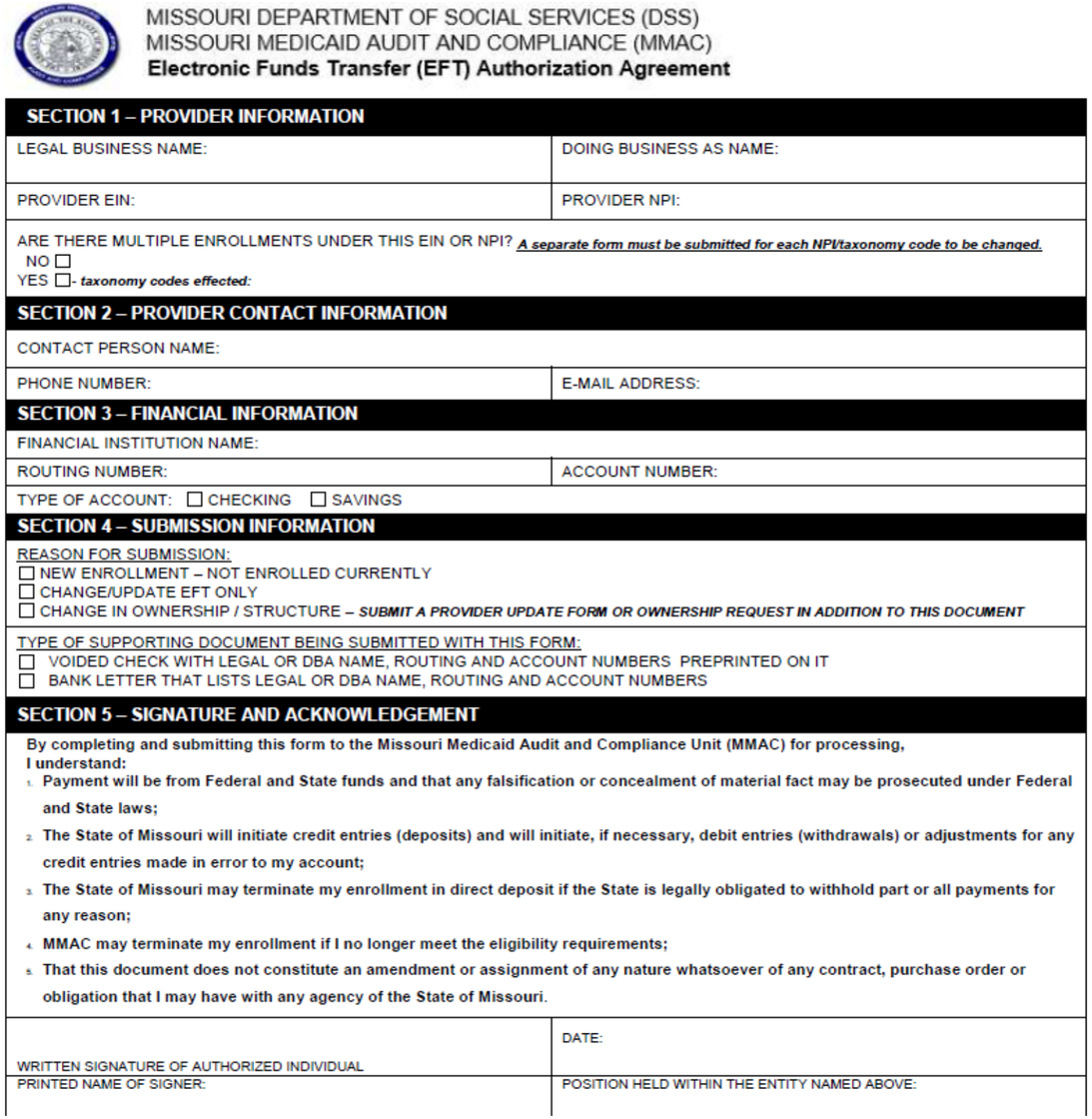
In Affirmation thereof, the facts stated above are true and correct: (The undersigned understands that false statements made in this filing are subject to the penalties provided under Section 575.040, RSMo)

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:**

Electronic Funds Transfer (EFT) Documentation

- Visit https://mmac.mo.gov/wp-content/uploads/sites/11/2020/09/EFT.pdf to access the EFT form.
- Form must be filled out and signed by someone listed on the Business Organizational Structure form.
- Supporting documentation must be included: Voided Check or Bank Letter.



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:

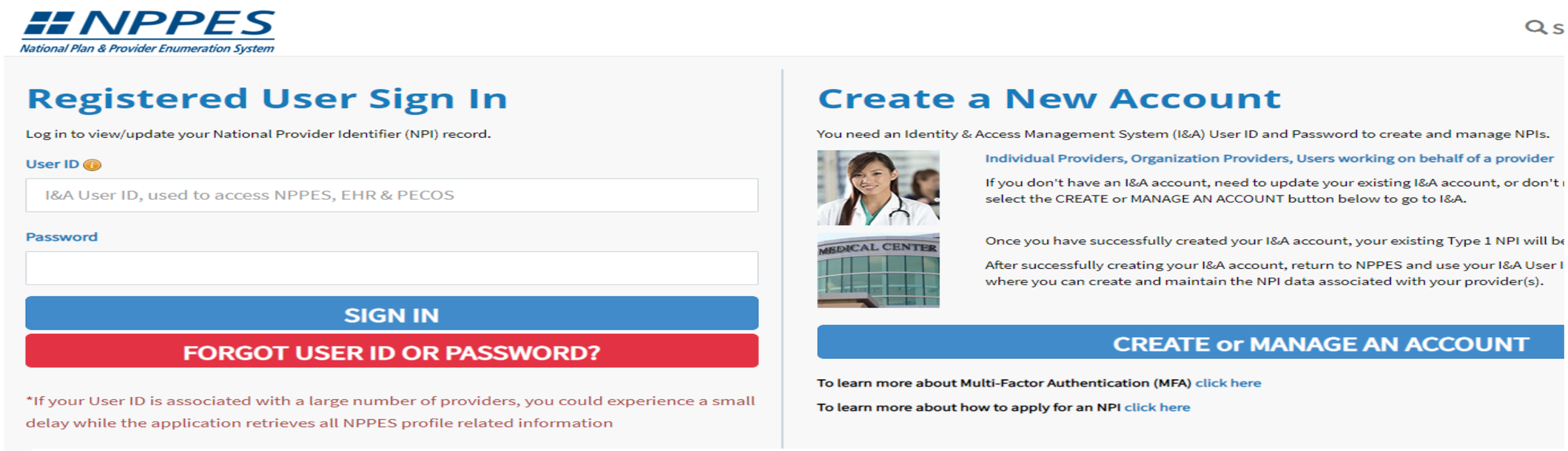
Children's Division Licensure

Must submit a copy of the organization's Children's Division license.

- The license must state the business is a Residential Treatment Agency for Children and Youth for the RT specialty or a Child Placing Agency for the FT specialty.

- Submit license to MMAC along with the enrollment application materials to MMAC.providerenrollment@dss.mo.gov

National Provider Identifier (NPI)



- All provider types must have an National Provider Identification to enroll with Missouri Medicaid.

- Go to https://nppes.cms.hhs.gov/#/ to obtain an NPI number.

Application Fee

- There is an application fee due for **all** “Institutional” Medicaid providers not enrolled with Medicare.

- Please follow the link below to Missouri Medicaid website. It explains why the fee is due, the cost of the fee, and where to go to pay the fee:

  https://mmac.mo.gov/providers/provider-enrollment/new-providers/application-fee/

- It’s recommended that you pay electronically using a credit card, debit card or e-check through the contracted state vendor, Jet Pay.

- The vendor will provide a receipt reflecting the application fee was paid which can be submitted to MMAC with your application.