MISSOURI DEPARTMENT OF SOCIAL SERVICES (DSS)
MO HEALTHNET DIVISION (MHD)

AUTHORIZATION BY CLINIC MEMBERS

(DIRECT DEPOSIT, OR PROVIDER ADDRESS, OR PAYMENT CHANGE)

CLINIC/GROUP NAME		
CLINIC/GROUP PROVIDER IDENTIFIER		
ORIGINAL SIGNATURE OF AUTHORIZED REPRESENTATIVE	PRINT NAME AND TITLE OF PERSON SIGNING	DATE SIGNED

I am the individual authorized to request direct deposit or change in direct deposit, or provider address, or payment change on behalf of all individuals listed below (including additional pages). I acknowledge that each individual has been informed of this request and that the payment due to this clinic/group will be either direct deposited to the specified account or mailed to the current payment address recorded in the MO HealthNet Division Provider Master Files. (This form must be signed by the person with fiscal responsibility for the clinic/group listed below (including reverse side). The same person must sign **both**, the Application for Direct Deposit **and** the Authorization by Clinic Members when direct deposit is requested.)

EACH individual provider employed at the clinic/group must be listed on the Authorization by Clinic Members before direct deposit can be approved, or a provider address, or payment change will be processed for the clinic provider identifier and individual members. **All other providers MUST** complete an individual: Application for Direct Deposit (for each provider identifier assigned) containing their individual provider identifier and **original** signature; an update provider application containing their individual provider identifier and **original** signature for provider address or payment changes; and **MUST** submit all forms along with the clinic application and Authorization by Clinic Members (when applicable). This form may be copied (**before** names and signatures are filled in) if additional lines are needed to include all members of the clinic. A separate Application for Provider Direct Deposit and Authorization by Clinic Members must be completed for each clinic provider identifier assigned. ****Any individual provider not listed on this form, or applications not received for providers required to submit an individual Application for Provider Direct Deposit, who are shown as members on the Provider Enrollment Unit group file will be made inactive. The provider will receive written notification if made inactive. **Inactivated providers are required to complete the appropriate form(s) before reinstatement is granted.**

INDIVIDUAL PROVIDERS
(TYPE or PRINT each provider name and individual provider identifier, please use medium BLACK ink.)

PROVIDER IDENTIFIER	PROVIDER TAXONOMY CODE	PROVIDER NAME	PROVIDER IDENTIFIER	PROVIDER TAXONOMY CODE	PROVIDER NAME

THIS FORM CANNOT BE FAXED

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