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

# LONG TERM CARE PHARMACY DISPENSING FEE PROVIDER SPECIALTY APPLICATION

## PROVIDER INFORMATION

Complete or affix provider label below:

| MO HEALTHNET PROVIDER IDENTIFIER | PROVIDER TQXONOMY CODE |
|---|---|
| | |

| PHARMACY NAME | BUSINESS TELEPHONE |
|---|---|
| | |

PHARMACY ADDRESS

## APPLICATION

| 1. FACILITIES FOR WHOM YOU DISPENSE IN UNIT-DOSE OR CONTROLLED-DOSE DRUG DISTRIBUTION SYSTEM. FACILITY NAME(S): EX-FACILITY NAME | 2. TYPE OF UNIT-DOSE OR CONTROLLED-DOSE DRUG DISTRIBUTION SYSTEM DISPENSED IN EACH FACILITY. DRUG SYSTEM FOR THAT FACILITY |
|---|---|
| | |

By my signature, I hereby certify that I provide the required distribution system as stated above, and that I provide emergency services and 24 hour a day, seven (7) day a week availability to the long term care facility. In addition, I am able and willing to assist the facility and its residents in accessing medications through the MO HealthNet exception process.

| PROVIDER'S **ORIGINAL** SIGNATURE | PRINT NAME AND TITLE OF PERSON SIGNING | DATE SIGNED |
|---|---|---|
| | | |

**RETURN TO:**
Provider Enrollment Unit
MO HealthNet Division
PO Box 6500
Jefferson City, MO 65102
email: providerenrollment@dss.mo.gov