



## Medicaid/Medicare Provider Information

1. Have you ever been terminated, denied enrollment, suspended, restricted by agreement, or otherwise sanctioned by Medicare, Medicaid, or any federal programs in any state? Incidents where notice of program deficiency resulted in voluntary withdrawal must be included. Yes or No. If Yes, give explanation.
2. Has your license ever been revoked, suspended, surrendered, or in any way restricted by probation or agreement by any licensing authority in any state? Yes or No. If Yes, give explanation.
3. Is there any proceeding currently pending to revoke, suspend, censure, or restrict by probation or agreement, your license in Missouri or in any state? Yes or No. If Yes, give explanation.
4. List all Medicare Provider Numbers you now hold both active and inactive (attach copy of Medicare letter or EOMB). If inactive, give reason for inactivation.

Name (print) \_\_\_\_\_ Name (signature) \_\_\_\_\_ Date \_\_\_\_\_  
Organization Name \_\_\_\_\_ Type of Service Provided \_\_\_\_\_