MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
DIVISION OF SENIOR AND DISABILITY SERVICES

Provider Communication Form

PARTICIPANT INFORMATION:

PARTICIPANT DCN	DOB	DATE

PARTICIPANT LAST NAME	PARTICIPANT FIRST NAME

ADDRESS	PHONE NUMBER

CITY	STATE	ZIP CODE	COUNTY

CHANGE REQUEST:

ADD	DEL	INC	DEC	Personal Care Task	Closing Requested	Check	Date
☐					Participant Died	☐	
☐	☐	☐	☐		Moved Out of State	☐	
☐	☐	☐	☐		Nursing Home	☐	
ADD	**DEL**	**INC**	**DEC**	**Advanced Personal Care Task**	Medicaid Ineligible	☐	
☐	☐	☐	☐		Unable to Locate	☐	
☐	☐	☐	☐		Unable to Self-Direct	☐	
☐	☐	☐	☐		Non-Compliant	☐	
ADD	**DEL**	**INC**	**DEC**	**Authorized Nurse Visits**	Participant Choice	☐	
☐	☐	☐	☐		**Other Requests**	**Check**	**Note**
☐	☐	☐	☐		21 – Day Notice	☐	
☐	☐	☐	☐		Provider Change	☐	
ADD	**DEL**	**INC**	**DEC**	**CDS Task**	**Details of Request/Additional Information:**		
☐	☐	☐	☐				
☐	☐	☐	☐				
☐	☐	☐	☐				
ADD	**DEL**	**INC**	**DEC**	**Waiver Service**			
☐	☐	☐	☐				
☐	☐	☐	☐				

Key: ADD=Add DEL=Delete
INC=Increase DEC=Decrease

PROVIDER INFORMATION:

PROVIDER AGENCY NAME	CONTACT NAME
PHONE NUMBER	FAX NUMBER

ADDRESS

CITY	STATE	ZIP CODE

Email:

NOTICE: Due to the increased volume of requests, all communication from DSDS will be directed to the email address provided above, unless a call is warranted. Please ensure you are checking your email address for the latest information related to your request.