MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF CANCER AND CHRONIC DISEASE CONTROL, SHOW ME HEALTHY WOMEN (SMHW)

SMHW NEW PROVIDER APPLICATION

WEB ADDRESS: www.health.mo.gov/showmehealthywomen

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PROVIDER INFORMATION

NATIONAL PROVIDER IDENTIFICATION (NPI) #	FEDERAL TAX ID NUMBER
AGENCY/DOING BUSINESS AS (DBA) NAME	STREET ADDRESS/PO BOX

CITY	STATE	ZIP CODE + 4 DIGITS	DAYS AND HOURS OF OPERATION

PUBLIC TELEPHONE NUMBER FOR APPOINTMENTS	ALTERNATE TELEPHONE NUMBER	FAX NUMBER

MEDICAID PROVIDER?	MEDICARE PROVIDER?	ESTIMATED NUMBER OF SMHW CLIENTS SEEN ANNUALLY
☐ YES ☐ NO	☐ YES ☐ NO	

CORPORATE/PARENT COMPANY NAME (IF DIFFERENT THAN AGENCY/DBA NAME LISTED ABOVE)	STREET ADDRESS/PO BOX

CITY	STATE	ZIP CODE + 4 DIGITS	TELEPHONE NUMBER

AGENCY NAME AND ADDRESS TO SEND CONTRACT DOCUMENTS (STREET, CITY, STATE, AND ZIP + 4 DIGITS)

SHOW ME HEALTHY WOMEN CONTACT INFORMATION

SMHW ADMINISTRATIVE CONTACT NAME	E-MAIL ADDRESS	TELEPHONE NUMBER
SMHW CLINICAL CONTACT NAME	E-MAIL ADDRESS	TELEPHONE NUMBER
SMHW BILLING CONTACT NAME	E-MAIL ADDRESS	TELEPHONE NUMBER

SMHW BILLING ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP CODE

WISEWOMAN CONTACT INFORMATION (IF APPLICABLE)

WISEWOMAN ADMINISTRATIVE CONTACT NAME	E-MAIL ADDRESS	TELEPHONE NUMBER
WISEWOMAN CLINICAL CONTACT NAME	E-MAIL ADDRESS	TELEPHONE NUMBER
WISEWOMAN LIFESTYLE EDUCATION (LSI) CONTACT NAME	E-MAIL ADDRESS	TELEPHONE NUMBER
WISEWOMAN BILLING CONTACT NAME	E-MAIL ADDRESS	TELEPHONE NUMBER

SMHW BILLING ADDRESS (IF DIFFERENT FROM ABOVE)	CITY	STATE	ZIP CODE

CYTOLOGY LAB

LAB NAME AND STREET ADDRESS (LAB THAT READS PAP TESTS)	CITY	STATE	ZIP CODE

LIST MAMMOGRAPHY FACILITIES (IF APPLICABLE)

1. MAMMOGRAPHY FACILITY NAME AND STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER
2. MAMMOGRAPHY FACILITY NAME AND STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER
3. MAMMOGRAPHY FACILITY NAME AND STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER
4. MAMMOGRAPHY FACILITY NAME AND STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER
5. MAMMOGRAPHY FACILITY NAME AND STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER
6. MAMMOGRAPHY FACILITY NAME AND STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER
7. MAMMOGRAPHY FACILITY NAME AND STREET ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER

LIST SATELLITE SITES (IF APPLICABLE)

1. SATELLITE SITE NAME	SATELLITE STREET ADDRESS	CITY	STATE	ZIP CODE
SATELLITE SITE DAYS AND HOURS OF OPERATION	TELEPHONE NUMBER FOR APPOINTMENTS	SATELLITE CONTACT PERSON		
2. SATELLITE SITE NAME	SATELLITE STREET ADDRESS	CITY	STATE	ZIP CODE
SATELLITE SITE DAYS AND HOURS OF OPERATION	TELEPHONE NUMBER FOR APPOINTMENTS	SATELLITE CONTACT PERSON		
3. SATELLITE SITE NAME	SATELLITE STREET ADDRESS	CITY	STATE	ZIP CODE
SATELLITE SITE DAYS AND HOURS OF OPERATION	TELEPHONE NUMBER FOR APPOINTMENTS	SATELLITE CONTACT PERSON		
4. SATELLITE SITE NAME	SATELLITE STREET ADDRESS	CITY	STATE	ZIP CODE
SATELLITE SITE DAYS AND HOURS OF OPERATION	TELEPHONE NUMBER FOR APPOINTMENTS	SATELLITE CONTACT PERSON		
5. SATELLITE SITE NAME	SATELLITE STREET ADDRESS	CITY	STATE	ZIP CODE
SATELLITE SITE DAYS AND HOURS OF OPERATION	TELEPHONE NUMBER FOR APPOINTMENTS	SATELLITE CONTACT PERSON		
6. SATELLITE SITE NAME	SATELLITE STREET ADDRESS	CITY	STATE	ZIP CODE
SATELLITE SITE DAYS AND HOURS OF OPERATION	TELEPHONE NUMBER FOR APPOINTMENTS	SATELLITE CONTACT PERSON		

LIST SATELLITE SITES (CONTINUED)

7. SATELLITE SITE NAME	SATELLITE STREET ADDRESS	CITY	STATE	ZIP CODE

SATELLITE SITE DAYS AND HOURS OF OPERATION	TELEPHONE NUMBER FOR APPOINTMENTS	SATELLITE CONTACT PERSON

8. SATELLITE SITE NAME	SATELLITE STREET ADDRESS	CITY	STATE	ZIP CODE

SATELLITE SITE DAYS AND HOURS OF OPERATION	TELEPHONE NUMBER FOR APPOINTMENTS	SATELLITE CONTACT PERSON

CLINICAL EXAMINERS/LICENSE INFORMATION

NAME (CLINICAL EXAMINERS PERFORMING SCREENING SERVICES)	TITLE	NURSE LICENSURE NO. AND/OR CERTIFICATE NO. (IF A NURSE PRACTITIONER OF ANY TYPE, INCLUDE RN LICENSE NUMBER)	PHYSICIANS LICENSE NUMBERS
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN ______ NP ______	PA ______ DO ______ MD ______
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN ______ NP ______	PA ______ DO ______ MD ______
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN ______ NP ______	PA ______ DO ______ MD ______
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN ______ NP ______	PA ______ DO ______ MD ______
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN ______ NP ______	PA ______ DO ______ MD ______
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN ______ NP ______	PA ______ DO ______ MD ______
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN ______ NP ______	PA ______ DO ______ MD ______
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN ______ NP ______	PA ______ DO ______ MD ______
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN ______ NP ______	PA ______ DO ______ MD ______

CLINICAL EXAMINERS/LICENSE INFORMATION (CONTINUED)

NAME (CLINICAL EXAMINERS PERFORMING SCREENING SERVICES)	TITLE	NURSE LICENSURE NO. AND/OR CERTIFICATE NO. (IF A NURSE PRACTITIONER OF ANY TYPE, INCLUDE RN LICENSE NUMBER)	PHYSICIANS LICENSE NUMBERS
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN ______ NP ______	PA ______ DO ______ MD ______
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN ______ NP ______	PA ______ DO ______ MD ______
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN ______ NP ______	PA ______ DO ______ MD ______
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN ______ NP ______	PA ______ DO ______ MD ______
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN ______ NP ______	PA ______ DO ______ MD ______
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN ______ NP ______	PA ______ DO ______ MD ______
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN ______ NP ______	PA ______ DO ______ MD ______
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN ______ NP ______	PA ______ DO ______ MD ______
	☐ MD ☐ DO ☐ RN ☐ NP ☐ PA	RN ______ NP ______	PA ______ DO ______ MD ______

I have reviewed the SMHW Provider Billing Guidelines for the Show Me Healthy Women Program. I understand all the screening guidelines and eligibility requirements and do hereby agree to comply. I understand this application will be returned if it is illegible, incomplete and/or not signed. I certify to the best of my knowledge and belief all information provided is true and accurate.

SIGNATURE	DATE

PRINTED NAME AND TITLE OF PERSON SIGNING

THIS SECTION FOR SMHW OFFICE USE ONLY

CONTRACT#	SITE CODE#	OFABS#	FFATA/TRACKING#
DUNS#	VENDOR#	COUNTY NAME	ORIGINAL START DATE
REGIONAL PROGRAM COORDINATOR		☐ LPHA ☐ CLINIC ☐ CHC ☐ HOSPITAL ☐ FQHC	SECOND START DATE