Iowa Department of Human Services

Claim for Targeted Medical Care

(If handwritten, use blue or black ink only. **Accuracy** is important.)
This form may be downloaded at http://dhs.iowa.gov/ime/providers/forms

Member Information

1. Medicaid ID Number	2. Member's Name

Provider Information

3. NPI Provider Number	4. Provider's Name
5. Provider Address	
6. Zip Code	7. Taxonomy Code

Other Information

8. Other Health Insurance ☐ Yes ☐ No	9. Other Health Insurance Denied ☐ Yes ☐ No
10. Other Health Insurance Payment	11. Client Participation Amount

Services

12. Procedure Code	13. Modifier	14. Place of Service	15. First Date	16. Last Date	17. Units	18. Total Line Charge
				19. Total Claim Charges		

Authorized Signature(s)

I certify that the statements on the back apply to this bill and are made a part of it.		*For consumer-directed attendant care claims only.*	
Provider Signature	Date	Member/Guardian Signature	Date

MEDICAID PAYMENTS

(PROVIDER CERTIFICATION)

I hereby agree:

To keep such records as are necessary to disclose fully the extent of services provided to individuals under the Iowa Medicaid Program, as specified in the Provider Manual and the Iowa Administrative Code.

To furnish records and other information regarding any payments claimed for providing such services as the Iowa Department of Human Services, its designee or Health and Human Services may request.

To accept, as payment in full, subject to audit, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductibles, coinsurance, copayment, and spenddown.

To comply with the provisions of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973.

I certify that:

The services shown on the front of this form were rendered to the consumer and were medically indicated and necessary for the health of the patient.

The charges for these services are just, unpaid, actually due according to law and program policy and not in excess of regular fees.

The information provided on the front of this claim is true, accurate, and complete.

I understand that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

PLACE OF SERVICE CODES

11	Office	51	Inpatient psychiatric facility
12	Home	53	Community mental health center
21	Inpatient hospital	54	Intermediate care facility/MR
22	Outpatient hospital	55	Residential substance abuse treatment facility
23	ER room hospital	56	Residential psychiatric treatment facility
24	Ambulatory surgical center	61	Comp inpatient rehab facility
31	Skilled nursing facility	62	Comp outpatient rehab facility
32	Nursing facility	71	Public health clinic
33	Custodial care facility	99	Other
34	Hospice		

Complete claim form instructions and a printable version of this form are available on our website: http://dhs.iowa.gov/ime/providers/forms