

CLAIM FOR TARGETED MEDICAL CARE

(If handwritten, use blue or black ink only. Accuracy is important.)

This form may be downloaded at <http://www.ime.state.ia.us/Providers/index.html>

MEMBER INFORMATION:

STATE ID:

MEMBER'S NAME:
(LAST, FIRST, MI)

PROVIDER INFORMATION:

NPI PROVIDER NUMBER: NAME:

PROVIDER ADDRESS:
(STREET, CITY, STATE)

ZIP CODE: TAXONOMY CODE:

8 **OTHER INSURANCE:** YES
(IF NO, LEAVE BLANK)

9 **OTHER INSURANCE DENIED:** YES
(IF NO, LEAVE BLANK)

10 **SERVICES:**

A.	B.	C.	D.	E.	F.
PROCEDURE CODE	* PLACE OF SERVICE	FIRST DATE MM/DD/YY	LAST DATE MM/DD/YY	UNITS	TOTAL LINE CHARGE
TOTAL CLAIM CHARGES:					11
CLIENT PARTICIPATION AMOUNT: (IF NONE, LEAVE BLANK)		<input type="text" value="12"/>		THIRD PARTY PAYMENT: (IF NONE, LEAVE BLANK)	
				<input type="text" value="13"/>	

* PLACE OF SERVICE (REFER TO CODES ON BACK)

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://www.ime.state.ia.us/Providers/index.html>